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Developments in Toronto

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NEARLY FIVE YEARS AGO, Miss Marjorie Jenkins of Nova Scotia, in a guest editorial in our *Journal*, put into words some of the questions and regrets that nurses everywhere felt in regard to our present pattern of nursing education. Miss Jenkins said:

> The hospital school of nursing seems to be the forgotten school in the field of education. Abiding under the shadow of the hospital, for the benefit of which it exists, it remains alone, unaided, outside the pale of public consideration. It proceeds largely untouched by modern educational enlightenment. Its growth and expansion are hindered by the character of its existence, being controlled by the hospital, whose main interest is its service to its patients. Financially dependent upon the hospital—for it has no budget of its own—it struggles along, crippled and unfree, deep in the mire of hopeless frustration.

A pretty gloomy, depressing and pessimistic picture, to be sure! Though there are many fine and progressive schools of nursing in Canada, at the time in 1946 when Miss Jenkins' editorial was published there did not seem to be much prospect of renovating the general pattern. Three vital criticisms were noted in that single paragraph—lack of adaptation to modern educational trends, control vested in the sponsoring hospital, financial dependence.

The first gleam of light on this dark scene came through the inspiration, interest, and persuasion of Miss Kathleen Russell. Acting on her proposal, the Canadian Red Cross Society met one of the problems by providing for the financial independence, for a definite period of years, of a demonstration school. It was duly arranged that this school—the Metropolitan School of Nursing, Windsor, Ont.—should be free from the pressure of total responsibility for the provision of nursing care. Thus planned and developed, the school has been able to provide a well-integrated, broad program of nursing education for a representative group of students in a shorter period of time than such a course customarily takes. Already the second class has graduated and the young women are participating actively in nursing duties in various communities.

Within recent weeks, another de-

velopment along somewhat similar lines has been announced. A grant of $100,000 from The Atkinson Charitable Foundation has made possible an immediate start on another two-year course in nursing at the Toronto Western Hospital. The aims of the program, which opened the middle of September with an initial enrolment of 80 students, are:

1. To accelerate the supply of nurses, which has fallen so far behind the need that the situation long has been critical.
2. To establish a streamlined curriculum, closely coordinating classroom and clinical studies, and designed to improve on present methods.

Mr. A. J. Swanson, superintendent of the hospital, stated that, in addition to the grant from the Foundation, assistance is being provided by the Ontario Department of Health, the federal Department of National Health and Welfare, and Toronto Western Hospital. A new educational building will be constructed immediately to provide the necessary classroom and laboratory space.

Under the present plan, the students will receive their complete grounding in nursing education in two years. They will then be required to serve an extra year as nurse internes, either in their own hospital or in one to be designated. They will be paid a salary during this year of internship. A future development, when the new course has been proven, might be the abandonment of the third year. The course will be guided by Miss Gladys Sharpe, director of nursing, and Miss Blanche McPhedran, associate director of nurse education, assisted by a group of highly qualified specialists for teaching purposes.

Thus, the morbid state of nursing education which Miss Jenkins decried is yielding place to active programs which promise to revolutionize nursing education in Canada.

Eye Emergencies

E. WOLSTEIN, M.D.

Average reading time — 5 min. 36 sec.

THE MOST COMMON eye emergency is that of a foreign body. The history is sudden pain in the eye and the patient usually feels the pain until the foreign body is removed. In examining the eye ask the patient to point with his finger to where the pain is greatest. In most cases that is where the foreign body will be found. Focus a good light on the affected eye and tell the patient to keep both eyes open. If he can do so it requires less manipulation on the part of the examiner. Have the patient move his eyes to both sides, then up, pull down the lower eyelid and a floating foreign body is often found. This is withdrawn with a moistened cotton wool applicator. If no foreign matter is seen evert the upper lid. In this manoeuvre the patient must look down while the upper lid is rolled back, either with one's finger or over a match held against the skin of the lid. If no foreign body is visible, and the pain persists, the patient should be referred to an ophthalmologist, as should the patient whose foreign body cannot be removed in the manner described.

When the history suggests an intraocular foreign body the affected iris will be seen projecting forward much more than in the other eye and the pupil is often distorted. Do not test the ocular tension for fear of reopening the original wound and losing aqueous or vitreous fluid. If

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in doubt, pad the eye and refer to an ophthalmologist at once.

A common eye injury is a corneal abrasion incurred by a finger scratch, a piece of wood, or a large foreign body that abrades the surface but does not embed. After ensuring that no foreign body is present, instil one drop of 2% fluorescin, wash out with normal saline, then examine the cornea. An abrasion will show up as a bright green patch. If it is small, instil 30% sodium sulfacetamide and pad the eye till the following day. If pain or the abrasion persists refer to an ophthalmologist. There is danger of infection with its sequelae of corneal scarring. A clean, superficial corneal abrasion heals quickly and without scarring.

Chemical injuries to an eye require immediate first aid treatment. Whether the chemical be alkali or acid irrigate the eye with *large amounts of fluid*—water, normal saline, boracic solution, or whatever bland fluid is at hand. Irrigate for five minutes, wait several minutes and irrigate again for five minutes. If the chemical is lime small particles may be seen on the surface of the conjunctiva. Instil one drop of ½% pontocaine and pick these out with fine forceps. Repeat the irrigation a few more times and refer to an ophthalmologist. The complications of chemical injuries to an eye are scars and their contraction.

The most common eye injuries due to exposure to radiant energy are the flash burns seen in welders and as the result of sudden sparking in power plants. The resultant pain may ensue immediately or be delayed up to twelve hours. The pain is due to minute corneal abrasions. These heal quickly after instilling castor oil and padding the eyes. It is not recommended that anesthetic drops be instilled in case further corneal damage results.

Lacerations in the vicinity of the eye must be carefully sutured, using fine black silk suture and fine needles to avoid scar contraction and distortion of the eyelids. When the laceration includes the margin of the eyelid it is best to refer the patient, as the lid must be sutured in layers.

The well-known black eye is due to hemorrhage in, or extravasation of, blood into the skin of the eyelids. If painful, a fracture of the orbital margin is a possibility. There is no effective therapy that will reduce the swelling and color of the condition in short order.

The differentiation between a stye and an acute chalazion is of interest. A stye is an infection of a hair follicle and it points at the margin of the eyelid where the hairs emerge. An infected chalazion, or meibomian cyst, is an acute infection of the meibomian gland and appears as a small rounded swelling away from the margin of the eyelid. The stye will disappear quickest by removing the lash at the affected point and applying heat several times a day. The acute chalazion partially subsides with heat but after the acute signs have passed a small mass remains which should be excised at a later date.

Another differentiation is that between conjunctivitis and iritis. The former is most often bilateral; there is a discharge, pain is rare, and the redness is greater away from the edge of the cornea. In iritis there is pain, no discharge, photophobia, pupil is small, cornea may be cloudy, and the redness is greatest at the corneal edge. If you are sure it is conjunctivitis instil 30% sodium sulfacetamide every three hours for two days. If the condition does not improve or if you suspect iritis in the first place refer to an ophthalmologist. If conjunctivitis occurs in several employees, school children, or members of a family within a week, conjunctival cultures should be taken of all affected eyes and investigation made to seek out the contagion.

Hot bathings of an affected eye are often ordered while the patient remains at his place of employment—e.g., in a case of stye or chalazion. The best procedure, one which causes no burn to patient or nurse and attains the maximum heat, is through the use of a wooden spoon whose bowl is covered by cotton wool. The

patient holds the spoon handle, dips the bowl into a pot of steaming water, and gradually brings it towards the affected closed eye. First the steam heats the eyelids then the covered bowl itself can soon be applied to the lids. When it cools, dip again in the steaming water and repeat. Such hot bathing should be carried on for at least 15 minutes and repeated every three hours.

This constitutes a summary of simple first aid procedures in cases of eye emergencies and the recognition of the common eye conditions which may be seen by nurses. Aseptic technique should be maintained, sterilizing all equipment before using it in a subsequent case in order to avoid contagion. The necessary equipment is as follows:

Irrigating flask, eye pads, cotton balls, adhesive, applicators with cotton wool heads, medicine glasses, lamp preferably on a stand, large condensing lens, ½% pontocaine, 2% fluorescin, 30% sodium sulfacetamide, goggles, dark glasses.

Detachment of the Retina

JEAN MCCULLOCH

Average reading time — 10 min. 24 sec.

IN PREPARING this material, I sincerely appreciated the opportunity of visiting one of our doctors who was receiving treatment for detachment of the retina. His description of the onset, with cause and symptoms, and also discussion of treatment made this a truly interesting assignment.

RETINAL DETACHMENT

The retina is the most delicate structure of the eye. It is connected with the subjacent choroid at the entrance of the optic nerve and at the ora serrata. Rays of light which fall on the retina are converted into nerve impulses which are carried by the optic nerve to the brain.

Retinal detachment is a separation of the retina from the choroid. Detachments are produced by a force which pushes the retina from the choroid or by a disease of the vitreous which pulls the retina from its bed. These forces may be:

(a) Inflammation and exudation—i.e., exudation of the choroid following acute choroiditis, renal retinitis, orbital cellulitis, acute scleritis, and similar conditions; (b) choroidal tumors; (c) injuries.

In a myopic eye there is an elongated eyeball with a resulting traction on the retina induced by ocular movements. If these eyes become inflammatory, adhesions may form between the hyaloid membrane and retina; retina and choroid. Trauma or straining on these adhesions may be caused by:

(a) Excessive forward bending of the head to pick up heavy objects from the floor; (b) putting on one's boots; (c) gardening or similar occupations.

Therefore, it may be seen that the part played by trauma is purely casual as trauma breaks that which was at the point of breaking. Some doctors advise moderation in or abstinence from drinking and smoking following retinal detachment as they feel this may have some effect on the predisposing cause.

Rents in the retina may occur without detachment. This is shown when traumatism occurs. Weeks or months may elapse before detachment occurs, as the retina does not detach until the edges of the wound are drawn

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Miss McCulloch, a V.G.H. graduate, prepared this material while she was a member of the post-graduate group in operating room technique at the Vancouver General Hospital.

towards the interior of the eyeball.

The patient usually first notices a sudden loss of vision in one part of the visual field, usually large and curved towards the interior of the eye. The patient complains of a "floating crescent" in the visual field or, if the tear is ragged, the shadow or curtain is "star-shaped."

The development of the tear varies greatly in different cases. Within a few hours the retina may become extensively detached due to the passage of fluid between the retina and choroid and, if untreated, this detachment may progress until a greater part of the retina is detached with almost complete loss of vision in that eye. More frequently the rent is small at first and increases as the days pass. Small rents may continue indefinitely without increase in size.

Upon ophthalmoscopic examination the area of detachment appears as a collection of greyish-blue or greenish folds projecting into the vitreous and shaking with movements of the eye. Careful search of the separated area usually reveals a hole. Detachment may occur anywhere on the retina but usually occurs on the temporal side. If it occurs at the ora serrata—i.e., point of insertion of retina—it is known as disinsertion. This latter tear cannot be seen with an ordinary ophthalmoscope. A gonioscope is used.

Examination of the visual fields reveals a loss of vision in that part of the field which is opposite to the detachment.

Medical Treatment

The patient is put to bed at once. He is placed on an "eye" mattress (this is a spring-filled mattress with a thinner mattress on top) with no rubber drawsheet and one pillow. In most cases the patient must lie flat on his back, but if the detachment is on the temporal side of the eye the patient may lie on the side of the injured eye. Complete bed rest is essential. Two nurses are needed to turn the patient—one to hold the head and one to roll the patient, if this is allowed. The patient is not allowed to shave, his diet is a "no-chew" one, and no aperient or enema may be given unless ordered by the doctor. Atropine drops 1% are instilled in both eyes b.i.d. This causes contraction of the ciliary body and rests the iris. The choroid is not pulled back and forth. Thus, if a spontaneous attachment should occur the retina would not be pulled away again. Pinhole glasses are applied immediately upon admission thus putting both eyes at rest as completely as possible.

Although rare cases of spontaneous reattachment have been reported following complete bed rest, the only effective treatment is surgical. The operative method now favored is that of diathermic coagulation aimed at creating a line of traumatic adhesive choroiditis around the hole or tear in the retina; when the sub-retinal fluid is allowed to escape, the retina falls back into position and reattaches itself to the choroid at these points. Early operation is necessary as results are seldom obtained if the detachment has existed longer than six months.

Preoperative Preparation

1. Immediate preoperative care on the ward:

(a) An enema may be ordered the night previous to operation.

(b) A thorough physical examination is done.

(c) A preoperative medication is ordered such as demerol or hyoscine—*never* morphine as this contracts the pupil.

(d) The patient is taken to the O.R. on a stretcher.

2. Immediate preparation in the operating room:

The patient is taken to the eye room, which is a dark room with the blind drawn during operations, and placed on a soft mattress on the eye table. Two small sandbags are placed on either side of the patient's head to hold it steady. The graduate nurse in charge of the room receives the patient and begins the local anesthetic by putting pontocaine ½% drops q. 5 min. for 20 minutes. Then, with gloves on, she proceeds to bathe the eyes, forehead, and face and then both

eyes again with absorbent and a solution of equal parts of saline and aqueous zephiran. The operative eye is then irrigated with the same solution. Having asked the patient which eye is injured and also checking with the chart, the scrub nurse proceeds to drape the head covering the good eye. Before gowning, the surgeon paints the operative area with an antiseptic—it may be iodine and alcohol solution or aqueous zephiran 1: 1000. The surgeon then proceeds to inject a local anesthetic—usually novocain 2% with or without adrenalin. A retrobulbar injection is also made with 2" No. 26 gauge needle. The eye is again irrigated with saline and aqueous zephiran and an eye sheet is applied. The surgeon is then gowned and gloved and proceeds with the operation.

Operative Procedure

The retinal tear is located. It is usually on the temporal side but, of course, may be located anywhere in the retinal area. A large semi-circular conjunctival flap is made with scissors over the tear. The external rectus muscle is caught and detached if necessary. Black silk sutures are inserted in the muscle to be used as traction and turn the eyeball so that the area to be punctured is exposed. This area should involve a sufficient amount of sclera to include much healthy retina beyond the limit of the hole. A fine iridium-platinum needle or multiple Walker needles are used—these are attached to a Rose Walker or diathermy puncture machine. A weak current, 40 to 60 milliamps, is used. Multiple punctures are made in a semi-circular way from the ciliary body. The operator allows the needle to remain in contact with the sclera for about one second in each puncture.

A second or even third barrage of punctures is made further away from the localized site of the tear. The object is to puncture the sclera and stir up congestion in the underlying choroid without penetrating the choroid or sub-retinal space. As soon as the desired number of punctures have been made, the needle is again inserted into the openings and carefully made to penetrate the sclera and choroid into the sub-retinal space. The sub-retinal fluid will be seen to exude through the openings. The eye is then inspected with an ophthalmoscope to see if the barrage has covered the desired area and also to make sure that the retina has become flat after punctures through the choroid. The muscle tendon is sewed into place and the conjunctiva sutured. Atropine 1% drops are instilled as well as penicillin solution. Metaphen ointment is applied to both eyelids and both eyes are covered with eye pads and shields held on with Scotch tape. The patient is then wheeled to the ward on the operating table and very carefully moved from the table to the bed with a nurse supporting the head.

Post-Operative Nursing Care

The patient is placed again on complete bed rest. All preoperative orders—metaphen ointment, atropine drops, codeine gr. ½ h., phenobarbital t.i.d.—are continued for the first two days post-operatively. Vitamin B is given as a tonic and vitamins C and K are given to prevent sub-retinal hemorrhage. On the 5th day an enema is usually ordered and by the 10th day the bed may be raised 10° increasing 30-60°. Usually by the 16th day the patient is allowed up but is cautioned against sudden movements, stooping over, or over-exertion. If the retina is in place and has not again begun to detach the patient is discharged at the end of three weeks post-operatively. Essential points in nursing care include:

(a) Avoid sudden or loud noises.

(b) Warn patient of your approach—speak quietly when entering room.

(c) Room darkened before dressings are removed.

(d) Explain how much and how little patient may move.

(e) Patient is fed for two to three weeks. Make meals as interesting as possible.

Prognosis

The outcome of this operation seems to be more and more favorable

with the use of diathermy puncture. A great deal of the success of the operation depends upon the age of the patient, the amount of detachment, and how soon the operation is done. Moreover, the complete cooperation of the patient aids greatly in final success. Therefore, the patient should be given an adequate explanation of the importance his cooperation plays in the ultimate result.

The Chemotherapy of Cancer

PHYLLIS BREWSTER TAYLOR, PH.D.

Average reading time — 16 min.

AS A RESULT of increased public interest in the cancer problem, followed by increased governmental and private grants for research, considerable progress in this field has been made in the last few years. Significant advances have been made both towards the elucidation of the nature and causes of cancer and towards specific methods of treatment.

A large volume of research is being published on the chemotherapy of cancer. Many compounds are known to be toxic to cancer cells; researchers are now directing their efforts towards modifying these structures so as to decrease their toxicity towards man and thus increase their specificity against cancer.

FOLIC ACID DERIVATIVES

A number of derivatives of folic acid (pteroylglutamic acid) have received clinical trial. Aminopterin (4-amino-folic acid), known to be an antagonist of the parent acid, injected intramuscularly into 16 infants and children suffering from acute leukemia caused marked improvement in 10 of these. Certain conjugates of folic acid accelerated the leukemia; thus, pteroyldiglutamic acid (diopterin) aggravated the condition in cases which later responded favorably to aminopterin.[1] On the other hand, clinical trial with 90 patients indicated that pteroyldiglutamic acid and pteroyltriglutamic acid are beneficial in the treatment of some malignant diseases.[2]

It is interesting to note that chicks maintained on a folic acid-free diet do not develop tumors when inoculated with Rous sarcoma virus. Also, the development of tumors in chicks on a normal diet is prevented by the folic acid antagonists—4-amino-folic acid, 4-amino-folic acid with D(–)–glutamic acid and 4-aminoaspartic acid.[3]

NITROGEN MUSTARDS

Methyl bis-(B-chloroethyl) amine and related compounds frequently induce temporary remissions in Hodgkin's disease, polycythemia vera, and lymphosarcoma. The toxicity of these compounds limits their use.[4, 5] Apparently all rapidly proliferating tissues are attacked by the nitrogen mustards, which are called "mitotic arrestors."

URETHANE AND OTHER DERIVATIVES OF CARBAMIC ACID

Urethane (ethyl carbamate) is a useful therapeutic agent in the treatment of chronic myelogenous leukemia. Approximately the same clinical and hematologic results are obtained as with standard x-ray therapy. Toxic symptoms are common, the chief being nausea and anorexia.[6]

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It has been found that the administration of urethane to rats inoculated with leukemia cells prevented the development of lymphatic leukemia in 91.1% of the rats as compared with 16.9% of resistant rats in the controls.[7]

Paradoxically, urethane and some other esters of carbamic acid are effective carcinogenic agents for the production of lung tumors in mice. The relative potency of the ethyl, isopropyl and n-propyl esters of carbamic acid as carcinogenic agents is approximately 81:4:1. The carcinogenic effect is exerted against pulmonary tissue whether the urethane is administered intraperitoneally, subcutaneously, or orally.[8]

Two other esters of carbamic acid—phenyl urethane and isopropylphenylcarbamate—cause retardation of spontaneous mammary cancers in mice.

Podophyllin

Preparations of crude podophyllin and its active principle, podophyllotoxin, cause severe tumor damage in test mice.[9] A study of the action of these agents on tumor cells and normal embryonic mouse fibroblasts and epithelial cells shows that podophyllin has a selective damaging effect on the tumor cells.[10]

Dyes

Certain azo dyes (e.g., germanin) have been shown to inhibit the growth of transplanted lymphosarcomas although only in doses toxic to the test animals.[11] In a study of 331 acridine compounds[12] it was found that a number of them administered to tumor-bearing mice in their food greatly retarded tumor growth. These compounds did not prevent tumor growth or cause regression of tumors; they did slow the rate of multiplication of tumor cells. Most of the compounds that colored the tumors also caused retardation of tumor growth.

Inorganic Radioactive Compounds

One of the radioactive inorganic agents being given clinical trial is a short-lived isotope of gold—Au_{198}. This isotope, which is prepared by neutron bombardment of Au_{197}, has a half-life of only 2.73 days and is, therefore, useful in the controlled radiation of certain tissues inaccessible to the standard methods of radiation by x-rays. Radioactive gold, in the form of a stable colloidal solution, has been used intravenously in the treatment of diseases of the lymphoid system; colloidal solutions of Au_{198} have also been used for direct injection into tumor masses.[13]

Radioactive phosphorus (P_{32}), in the form of a solution of phosphate, continues to be used in the treatment of myelogenous leukemia. P_{32} provides a convenient method of giving generalized radiation without the disadvantage of radiation sickness. While it ordinarily does not prolong the life of the patient, it does cause a remission of the unpleasant symptoms for long periods.[14]

A study of the phosphates of the radioactive elements plutonium and yttrium has shown that, far from being therapeutic agents, they induce fibrosarcomas in test animals.[15] There is evidence that arsenic, also, may be a carcinogenic agent,[16] although arsenic compounds have been useful adjuncts to roentgen therapy in controlling myelogenous leukemia.[17]

Sodium fluoride and sodium azide have had a favorable effect in a number of cases of advanced cancer and leukemia in man.[18]

Bacterial Products

It has been known for many years that the injection of certain bacterial products into test animals will bring about the necrosis of transplanted tumors. At the present time considerable research is being carried on to determine the mechanism of action of these products and to find preparations suitable for clinical use.

When mice, bearing transplanted sarcomas, are infected with certain organisms, a rapid destruction of tumor tissue occurs. Unfortunately, these organisms are usually themselves fatal to the animals unless they can be protected against the result of the infection in some way. For example, if tumor-bearing mice are

infected experimentally with *Clostridium histolyticum* and the infection controlled by injection of histolyticus antitoxin, the life span of the animals is prolonged beyond that of the non-infected tumor-bearers. That the tumor tissue is not completely destroyed is shown by the fact that mice treated with penicillin to eradicate the remaining infection develop large sarcomas.[19] In another test, mice with carcinoma grafts were treated with *S. cruzi* endotoxin. The endotoxin prevented the development of tumors in 19 out of 43 mice and brought about definite inhibition of growth in the others. In an equal number of controls, all the tumors developed well. Where the animals were infected directly with *S. cruzi* organisms, the carcinomas receded in 30 out of 45 mice although the animals later died of the infection.[20]

It has been found that a polysaccharide from *Bacillus prodigiosus* is able to bring about complete necrosis of tumors in experimental animals. Apparently, the tumor damage is due to vascular occlusion followed by hemorrhages throughout the tumor. In every instance, however, some peripheral cells survive and growth of the tumor is resumed.[21]

Another tumor-necrotizing polysaccharide has been isolated from *S. marcescens* but the clinical application is difficult because of its toxic effects. The distribution of the polysaccharide in mice, rabbits, and man has been studied by tagging the polysaccharide with a radioactive iodine atom.[22]

Alkaloids

Several alkaloids are known to bring about tumor damage in mice. Two of these are emetine and colchicine. Colchicine has been given clinical trial in the treatment of animal tumors and human leukemia; however, its toxicity prevents the use of doses large enough to produce more than a temporary effect.

Tumor Antisera

In experiments involving 220 young chicks it was found possible to protect the birds against the injection of lymphoid tumor cells by incubating the tumor cells before injection with lymphoid antiserum. The antiserum was prepared from chicks that had received repeated injections of killed lymphoid tumor cells. Injection of the antiserum into birds bearing tumor implants caused a partial or complete suppression of the tumor growth.[23]

Conclusion

Many theories have been advanced to explain the origin of cancerous tissue. Any such theory must account for the alteration in cell characteristics responsible for the differentiation of cancer tissue from normal tissue. In assembling and condensing the mass of data published in connection with the cancer problem, one cannot help being struck by one outstanding paradox: many agents known to be carcinogenic are being employed with favorable results in the treatment of malignant disease. Thus we have ethyl urethane, shown experimentally to induce pulmonary tumors in test animals but clinically effective in bringing about the temporary remission of leukemias. As another example, we might consider the experimental evidence regarding the relationship of hormones to cancer; while estrogens have been shown to be carcinogenic in some test animals and are widely suspected as causative agents in humans, they are used in the treatment of some malignant growths. Certain azo dyes retard tumor growth yet others are known to initiate the growth (e.g., the hepatic carcinogen p-dimethylaminoazobenze). Even the powerful carcinogens such as 1, 2, 5, 6-dibenzanthracene are found to inhibit some types of cancer.

Two reports not directly related to the topic of chemotherapy, but of possible interest, may be mentioned here. It has been reported[24] that propylene glycol injected subcutaneously in rats causes leukemia. No report of leukemia arising from the oral administration of the glycol has been made. In view of the increasing use of this substance, both

as a solvent and as an agent for sterilizing air, further research is indicated to determine whether propylene glycol is actually a carcinogenic agent.

The effect of high frequency sound waves on cancer tissue is under study at one American university. The ultrasonic rays can be focused on the cancer tissue so that less damage to the surrounding tissue results than by x-ray irradiation.

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Home Thoughts from Afar

'Mid silvery birches, murmuring pine,
Where fairy sunbeams dance and shine,
I've lived and played these happy days,
And walked the rustic, rugged ways;
Beside the waters, deep and blue,
'Neath wide clear skies of sapphire hue,
Where moss the ancient rocks adorn,
And fragrance on the breeze is borne.

I've met dear folk from other lands,
Exchanged a greeting, shaken hands,
And when a kindred soul I meet,
We find a fellowship that's sweet.
Yet this communion never lends
The joy of tried and trusted friends,
Whose worth is proved across the years,
We've shared our work, our joys, our tears.

And so tho' here is rest and peace,
From daily toil a short surcease,
My thoughts turn back in time and space,
To see again each well-known face;
To hear each well-remembered voice
Will surely make my heart rejoice.
Oh, yes, it's nice at times to roam,
But, best of all, is coming home.

—M.M.F.

The Menopause

F. GIBSON, M.D.,C.M.

Average reading time — 7 min. 36 sec.

THE MENOPAUSE heralds the end of the reproductive life of the woman. The manifestations of this critical change have been recognized since the time of Hippocrates. Progress in the fields of physiology, endocrinology, and psychiatry have clarified some of the mysteries but many of the phenomena still remain enigmatic.

The menopause is that period of life characterized by a complexity of phenomena—the central symptom of which is menstrual cessation—but also accompanied by circulatory and psychosomatic manifestations. Strict interpretation of the term "menopause" would limit its use to express merely the cessation of menstrual flow. The more applicable term, "the climacteric," describes the events which transpire during the transition from the reproductive period to senility. By tacit consent, however, the term menopause has won preference among the profession and the laity and will be employed to include all the events of this epoch.

It has been established without doubt that essentially all the phenomena are due to a gradual diminution in production of the ovarian hormone as a result of aging of the ovaries. A proper understanding of normal ovarian function is, therefore, necessary to comprehend the vagaries of the menopause.

It is generally stated that the human ovary at birth contains all the formed ova to last through a woman's reproductive period. Monthly, after puberty, one of these ova is involved in the formation of a follicle under the stimulation of the follicle-stimulating hormone liberated by the anterior lobe of the pituitary gland, situated at the base of the brain. As the follicle grows in the ovary, it expands and develops a cavity filled with fluid containing the follicular hormone specifically known as "estrin." This substance finds its way into the bloodstream to exert its influence upon the breasts, uterus, and vagina. When the follicle has reached maturity—the midpoint of the menstrual cycle—it ruptures and the ovum is extruded (ovulation). The collapsed follicle undergoes further changes and from this point, in its role as the corpus luteum, secretes progesterone which augments the effects of estrin upon the breasts, uterus, and vagina in the latter half of the cycle. With corpus luteum degeneration and consequent progesterone withdrawal the thickened endometrium is shed off and menstrual bleeding occurs.

By the end of the reproductive span, the ovaries are depleted of all their eggs by monthly ovulation and when the loss of ova is complete the ovary becomes inactive as an endocrine organ. It is at this stage that the change of life takes place. Follicular function may still occur without ovulation and this process accounts for the gradual diminution in hormonal activity in the presence of the cessation of the menstrual periods.

ONSET OF THE MENOPAUSE

Menopausal onset can be either a natural occurrence or artificially induced. The latter is provoked by:

(a) Radium insertion—or deep x-ray of sufficient dosage to cause atrophy of the ova and the follicular system.

(b) Surgical means — complete extirpation of both ovaries.

The symptoms in the two types are identical, except that in the artificially induced menopause the onset is more abrupt and the symptoms are usually more pronounced.

Dr. Gibson is resident in obstetrics and gynecology at the Royal Victoria Montreal Maternity Hospital.

The average age of onset is 45-50 years. Precocious onset has been recorded as early as the middle twenties and as late as the nineties.

The menopause, like puberty, depends upon the individual's potentiality. If the ovarian function starts early, indicating a virile gonad, its function will have a tendency to last longer with a natural delayed menopause. Conversely, late puberty bespeaks an early menopause.

Racial extraction appears to have some bearing upon the age of onset. Northern and Anglo-Saxon types tend to be later, while southern and oriental types tend to be earlier in onset than average.

Obese women are likely to have some endocrine upset and for this reason have an inclination toward an early menopause.

Climate, race, and previous state of health all affect the onset. Ovarian function is exhausted early in women weakened by chronic diseases.

Symptoms

The gradual diminution or sudden cessation of estrin production is probably the immediate endocrine cause of menopausal symptoms. The essence of the menopause is the cessation of menstrual flow. This may occur in the following ways:

1. Gradual diminution in flow from month to month.
2. Increasing intervals between periods.
3. Alternating months of reduced flow and excess flow.
4. Irregularity as to intervals and amount of flow.
5. Sudden cessation of flow.

The duration of this change may last between six months and three years. The symptoms can be listed generally as follows:

1. Hot flushes—which are essentially evidence of vasomotor instability. They can be described as a sudden sensation of heat and burning which sweeps over the body, reaching the greatest intensity over the exposed surfaces. An intense flushing of the face is sometimes visible. A feeling of suffocation as well as faintness is often described. Beads of perspiration may sometimes follow the flush. The frequency and intensity of the flushes vary from individual to individual. They may be so pronounced in some women as to awaken them at night.
2. Palpitations.
3. Emotional instability — usually mild, as evidenced by: (a) Fatigue, (b) insomnia, (c) weeping, (d) headaches, (e) dizzy spells.
4. Flatulence, constipation, and vague, diffuse abdominal pains.
5. A tendency to altered fat distribution and obesity.
6. Eczema, pruritus, and acne may appear.
7. Vague diffuse joint pains (arthralgias).

It should be emphasized that all symptoms do not occur in one individual. It is more common to find one symptom predominant or a combination of several. It has been estimated that about 85 per cent of women pass through this period without any disturbances of consequence. Of the remaining 15 per cent, the majority have only mild disturbances, while it is the rare case that exhibits significant changes.

Treatment

The management of the menopause can be dealt with in two phases—general and specific.

General management: In spite of a healthy attitude generally among women as to the significance of the menopause, there are still many misconceptions. All women at the menopause, or preferably before, should be reassured that the menopause is not a period to be dreaded. They should be firmly advised that it is a period of glandular readjustment as a result of aging of the ovaries and many of the symptoms are natural phenomena, which, if sufficiently severe, can be relieved by the proper therapy. All fears and superstitions should be eliminated. Every woman should be made to understand that the menopause does *not* usher in any change in libido, of facial or body configuration, or personality changes bordering on insanity. The first step, then, is *reassurance and the elimination*

of fears and superstitions. If the symptoms are mild then reassurance may be all that is necessary. Mild sedation may be required.

Specific therapy: When the symptoms are moderate or severe then specific therapy is indicated. This consists of oral or hypodermic doses of hormones. The hormones used may be either the ovarian hormones, estrogen and progesterone, or the male hormone, testosterone. Synthetic estrogens, such as stilbestrol, are the most popular because of their minimal cost, yielding at the same time a corresponding potency to the natural estrogens.

Initial therapy consists of daily doses of the hormones sufficient to control the symptoms with gradually decreasing maintenance dosage to maintain control. Women should be advised that medication must continue over a long period of time.

Post-Menopausal Period

Any woman who experiences bleeding or spotting following the complete cessation of menstruation should consult her physician. Cancer of the cervix and uterus are most common during this period.

Summary

1. The phenomena of the menopause are due to gradual diminution of estrogen production as the result of aging of the ovaries.

2. It is not a period to be dreaded, not all women have symptoms, and all those who do can be relieved entirely by proper therapy.

3. Treatment consists of: (a) reassurance, elimination of fears; (b) sedation; (c) replacement hormonal therapy.

4. Irregular bleeding during or after the menopause is the signal to consult your physician.

Building Maturity

Cecelia May Schram

Average reading time — 5 min. 36 sec.

I PICKED UP my son's spelling paper today, glanced quickly over it for errors and, seeing none, rolled it up and threw it away. I had words ready if he had made many mistakes but no words for this surprising perfection! Startled by this thought, I removed the paper from the waste-basket, smoothed it out, and placed it on the kitchen table. There it would remind me to say the words a good spelling test deserved.

Many parents forget at times to give their children the appreciation and praise they deserve. Words of criticism come easily and are apt to become a habit. It would be helpful if parents were reminded to watch the words they use each day. Too often mistakes are emphasized and opportunities for praise are thrown into the waste-basket.

In his book, "The Substance of Mental Health," Dr. George H. Preston emphasizes again and again the importance of love and praise to a child in building sound emotional and mental maturity. He gives first place to an understanding love and second to praise. Dr. Preston says that love is the first element and "praise is the second element which is necessary in a home if that home is to provide a firm foundation for mental health." Praise gives the child confidence in himself and love gives him confidence in other people. The two together build up an inner security that helps the child in all his future relationships.

Both praise and love must be expressed in words. A mother may tell everyone else how much she loves

Mrs. Schram is a graduate of Victoria Hospital, London, Ont.

her child, yet neglect to tell the child himself.

John's mother loves her small son very much, yet she is always finding fault with him. His hair is not combed! Can he never remember to clean his teeth? What a stupid boy he is to lose his cap! How can John know that his mother loves him?

Children think that their parents know everything. If their father or mother continually calls them stupid, they believe they *are* stupid. "Children learn to estimate their own value in the world from the opinion of their parents." If children are made to feel ignorant and unwanted in their own homes, they will feel the same in their contacts away from home. Words of love and praise can give a child a sense of his own worthwhileness.

Recently, I had reason to be interested in a case which convinced me more than ever of the importance of love and praise in the parent-child relationship. It was about a year ago that a friend of mine came to me, very much disturbed about her ten-year-old boy. This is the story as she told it to me.

Summer vacation had been very enjoyable that year. There was closer contact and warmer relations among all the members of the family than there had been for years. Father's financial worries were much less now and mother and sons seemed to find new life under the lessening of tensions. Then school began for the fall term.

The first day of school, ten-year-old Tom went as far as the school door and then came home crying and shaking. He was clearly terrified and could not force himself to go into the school. He was a reasonable child and knew that he was behaving unreasonably, yet he couldn't force himself to act in his usual normal way. Every day for weeks he started out for school two or three times, only to return home again and again until he could summon up enough courage to go into his classroom.

If this had ever happened before, Tom's mother would not have been as concerned as she now was. Even in his kindergarten years, Tom had never been upset about going to school. Now, any separation from his mother had become a terrifying experience.

Tom refused to stay alone even for a short time. He cried when his parents would go out for the evening and leave him with friends. He gradually withdrew from his own friends and spent his time reading or listening to the radio. His mother was overwhelmed that her seemingly happy little boy should have developed into this fear-ridden, agitated child.

We checked with Tom's teachers to see if there was any trouble there that might relate to this condition but found everything at school entirely satisfactory. His mother took Tom to a doctor to see if there was anything wrong with him physically but found his health to be excellent. Now we decided to consult with a psychologist that we both knew and the advice that this woman gave Tom's mother is the same as that which should be given to every mother—"Love your child more and don't be afraid to tell him that you love him!" Tom's insecurity could only be overcome by the assurance that both his parents were proud of him and that they both loved him. Somewhere along the way he had lost the assurance that he was important to his family and that he was really wanted.

It is easy for a child to get the impression that he is not loved enough or wanted by his family. Sometimes a younger brother or sister demands so much attention that the older child feels left out of the group. Sometimes mother and father are so busy with their own problems that they forget to take time to listen to their children and take an interest in their affairs.

In some cases, the parents are so anxious to have children that conform to all the rules that they spend the time they should be loving their children in nagging them. It would help if parents occasionally took word inventory—how many times they said "stop," "don't" and "behave" against the number of times they found opportunity to give praise and affection.

Tom is a much happier boy now. When both parents realized how much

he needed their attention, it was only a matter of time until he became more sure of himself. He is not entirely cured. It took years for this feeling of insecurity to develop and it will take years for it to entirely disappear.

Tom's parents were like many other parents in that they had not consciously neglected him—they had only been thoughtless. They knew that they loved Tom and they thought he knew that they did. He was a good, quiet child and had never demanded special attention; consequently his need for attention had not been realized.

So let us remind parents that children need to be *told* that they are loved and that their mother and father are proud of them. Children need warmth and affection to grow to a healthful maturity. They need to be hugged and kissed once in a while. The toughest little "cowboy" on the street still wants those kisses, though he wouldn't admit it for the world.

Don't let those mothers and fathers forget to give their children the love and praise they deserve. As Dr. Preston says, "It cannot be any fun to be little and weak and always wrong and to have it rubbed in."

Naval Medicine

WALTER M. LITTLE, M.D.

Average reading time — 7 min. 12 sec.

YOU MAY ASK what qualifications I have to discuss naval medicine. From 1942 till 1945 I served in the Royal Canadian Naval Volunteer Reserve, not as a medical officer but as an executive officer. When I joined the navy I had completed three years of medicine at the University of Toronto. On discharge in September, 1945, I returned to medicine. However, the navy was still of interest to me and I joined the Naval Reserve—first as an executive officer (retired) and then, after obtaining an M.D., as a Surgeon Lieutenant in the active reserve.

What is the organization of medicine within the navy? The department is headed by a surgeon captain. Administrative policy is handled from Ottawa. Roughly speaking the chain of command passes from Ottawa to the Command Medical Officer in the various commands and then to the main hospitals. We will consider the East Coast as I am more familiar with the organization there. The Command Medical Officer is responsible for all medical organization and services within the command. He has the Royal Canadian Naval Hospital in Halifax — a large, modern, fully equipped hospital. This is equipped to handle all aspects of medicine and surgery and their allied specialties. There are various sick bays at the smaller ports. In the dockyard at Halifax there is a good-sized sick bay which is the naval version of a general practitioner's office. It handles the men from the dockyard and from the ships not large enough to carry a medical officer. Men requiring hospitalization are sent to the R.C.N. Hospital. In most of the smaller vessels with no medical officer there is a "tiffy"—a sick berth attendant who is a combination of male nurse, pharmacist, and jack-of-all-trades. Aboard the larger ships—frigates, destroyers, etc.—there is a medical officer with at least one "tiffy." These ships are fully equipped to handle any emergency, an appendectomy, or even major surgery. Major surgery is avoided and transferred ashore, if

Dr. Little presented this material in an address to the Goderich (Ont.) Community Nursing Registry.

possible, because it is felt that the added difficulties of an operation at sea are an unnecessary added risk to the patient. Consequently, conservative therapy is the rule when possible. There are also some small harbor craft attached to the sick bay in the dockyard to transfer sick men from a ship to shore.

At the R.C.N. Hospital in Halifax there is a Well Baby Clinic for the children of naval men. To this clinic, two afternoons a week, the mothers bring their young children for physical examination, changes in formula and feedings, and immunization. Approximately 30 babies are seen each afternoon. There is a full-time nursing sister at the clinic as well as the medical officer who is there each afternoon the clinic is open.

What are the duties of a medical officer in the active reserve? He examines recruits, both for the permanent service and the reserve, lectures in first aid and other medical subjects, and attends to any medical emergencies that may arise during the three-hour parade each week. In addition he must spend at least two weeks a year on active service, either in a sea-going ship or at the R.C.N. Hospital (or some similar appointment). The reserve medical officers are also kept up to date in navy matters by occasional refresher courses.

What are the requirements for and the advantages of being a medical officer in the permanent force? The man must, of course, have a medical degree and be of suitable character and personality to be likely naval material. He should be of a type that will be "happy in the service." His pay is not large when compared with the income of the average civilian doctor. It is in the neighborhood of $4,400 per year for a Surgeon Lieutenant (married) but this is almost pure profit. The navy supplies all instruments, books, and professional magazines. The hours are reasonable with a minimum of night calls. The atmosphere is pleasant and he is dealing with a relatively healthy group of men who suffer as a rule from acute conditions with a minimum of chronic complaints. One year in five is spent in a sea-going ship and one year in five in a civilian teaching hospital taking post-graduate training in whatever specialty the doctor wishes.

One of the recently publicized advances in naval medicine is the provision of a sea-sick remedy. The formula has been released to civilian doctors. It is also of value for other forms of motion sickness such as car sickness. Until the past war, therapies for sea sickness were largely based on the individual experiences of the advocator of the particular remedy and not upon tests with adequate controls. However, in 1940, when it was obvious that a large-scale invasion would be necessary to regain Europe, the National Research Council, in cooperation with similar groups in the U.S.A. and Great Britain, began to study the problem. Trials on swings were used, preliminary to trials at sea. The formula recommended by the National Research Council contains hyoscine hydrobromide, hyoscyamine hydrobromide, and a thiobarbiturate.

Public health and preventive medicine play a large part in naval medicine. Let us consider some of the obstacles and the methods of overcoming them:

Crowded conditions: This factor plays a very important part in the spread of communicable disease. When you consider that 40 men eat and sleep in a space approximately 30 feet by 30 feet and low enough to require a tall man to duck to avoid the pipes you can understand the problem. In the newer ships they are separating the eating and sleeping quarters. This, of course, requires larger ships than before. In the newer ships they are experimenting with folding bunks instead of the traditional hammock. The hammock requires little storage space when rolled and in a heavy sea the ship rolls about the hammock and it is, therefore, easier to stay in a "mick" than in a bunk. Due to the crowded conditions it is often necessary to quarantine the whole ship if an epidemic breaks out aboard.

Water and sanitation: The provision of good drinking water at sea is a problem. Fresh water must be carried or distilled from salt water at great expense. The fuel

used for this purpose may be of value to get the ship into port after a long run. Consequently, fresh water for showers and washing of clothes at sea is prohibited or greatly restricted. Salt water is used for sanitary facilities.

Clothing: This should be as light, as warm and as easy to keep clean as possible for the North Atlantic in winter. The usual dress for look-out duty in winter consists of two long woolly suits of underwear, two or more trousers, several sweaters, a long naval scarf, woollen mitts, balaclava for the head, a sheepskin-lined coat, heavy waterproof boots, and possibly oilskins over this. One looks like "Mr. Five-by-Five!" During the war a light-weight warm suit, complete with several zippers, was developed to cover one from the top of the head to the ankles. Other improvements have or are being developed in the clothing line.

Preparation of food: The galley is very small but it is a very important essential. It is about the size of an ordinary kitchen. Here are prepared the several meals and snacks for a crew of over 100 hungry men. In addition to the problem of limited space there are the difficulties presented by a rolling ship. The stoves are fitted with "fiddles"—iron bars which divide the stove top into several small compartments to keep the pots and pans from shifting. In spite of all the difficulties, shipboard meals are usually very good.

Life-boat equipment has received the attention of the medical profession. In place of the old-fashioned hardtack—that brick-like biscuit—we now have tinned and water-proofed packaged foods of high nutritional value.

Progress has been made in both the prevention and cure of *venereal disease.* The former has been accomplished through education and a common sense approach to the problem as well as provision of prophylactics. The latter has been achieved by the use of sulfa drugs and penicillin. Without quoting any figures on the subject let me use an example. There were very few times that our ship sailed in 1942 without leaving at least one man in hospital with gonorrhea. In 1945 I do not remember leaving one man behind because of this disease.

Immunization plays a very important part in naval medicine. In addition to the usual immunizations—smallpox, diphtheria, typhoid, paratyphoid A and B, tetanus, etc.—men received immunization for any special diseases to which they were likely to be exposed (when immunization was available for the disease).

This has been merely an introduction to naval medicine, a mere skimming of the surface, but it does help to give an idea of what goes on behind the scenes. The various techniques, therapies, and experiments of civil medicine all have their counterparts in naval medicine.

Growth Differences

Individual differences in the growth of a selected group of people from the prenatal period to death and through several generations of their descendants will be investigated in the United States. The purpose of the study is to correlate physical, mental, and emotional factors over a long period in order to develop more reliable methods for determining patterns of normal and healthy growth. The project is under the direction of Dr. Alfred Hamlin Washburn, of the Child Research Council, Denver, Colorado.

Continued investigation of 166 persons will be made by 20 research workers in such fields as pediatrics, physiology, biochemistry, hematology, nutrition, and psychiatry. A single aspect of the study will involve the physical and physiological changes of the head, teeth, skeleton, sinuses, and lungs as revealed by periodic x-ray.

—*U.S. Public Health Service*

The first step toward getting along with people is to build the habit of looking for their good qualities. If you look, you will find them. Conversely, one can easily fall into the tragic, self-defeating habit of disliking people, by thinking of and looking for only the mean, small, despicable qualities in humankind.

—K. C. INGRAM

Hints on General First Aid

O. HOFFMAN, M.D.

Average reading time — 6 min. 24 sec.

INSTEAD OF A formal outline of first-aid treatment it is proposed to discuss certain injuries with emphasis on the principles which guide one's choice of procedure. There is considerable variation of opinion regarding some aspects of first-aid treatment and it should be understood that this information offers but one opinion in these matters. Four major groups of injuries will be discussed: wounds; soft tissue injuries with intact skin; fractures; burns.

WOUNDS

These are injuries in which the continuity of the skin surface is interrupted. Our chief concern is the control of infection, following which we wish to put the injured tissue at rest and allow natural healing processes to restore structure and function as completely as possible. The time factor is important in controlling infection. Wounds receiving treatment within six hours of the time of injury can be given the benefit of primary closure. After six hours the incidence of a complicating infection rises sharply.

(a) *Antiseptics:* When the skin surface is intact, strong antiseptics can be used to kill bacteria without injury to the body tissues (iodine and alcohol, anilines, mercurials, quaternary ammonium compounds). In an open wound an antiseptic strong enough to kill most bacteria is also strong enough to injure or kill body tissues, which are already damaged. This interferes with normal healing processes and provides a medium for the growth of bacteria which may gain access to the wound after the antiseptic has been used. Hydrogen peroxide is relatively harmless and may be used to irrigate a wound. Where gross contamination has occurred powdered sulfathiazole is favored by some physicians. The most widely accepted routine is to wash the adjacent skin area with green soap and normal saline under aseptic conditions. The wound may then be irrigated with freely running normal saline.

(b) Any *hair* in the wound region should be clipped.

(c) *Débridement:* Any foreign material in the wound should be removed as well as obviously devitalized tissue.

(d) *Closure:* In gaping wounds: sutures or clips. The latter are useful in areas where surface skin is loose and where cosmetic results are not of primary importance. Adhesive tape "butterflies," sterilized by flaming, are sometimes enough to keep tissues in apposition.

(e) *Dressings:* In primary closure of a clean laceration a dry dressing is adequate. In abraded or irregular wounds sulfathiazole emulsion is a satisfactory dressing. Rest the injured part. Do not change the dressing unless it becomes contaminated or unless there is evidence of infection in the wound. Adherent dressings should be moistened with sterile saline or peroxide before removal is attempted. Deep punctures or badly contaminated wounds indicate the use of anti-tetanus serum.

In wounds of extremities (particularly hands and fingers) watch for evidence of damage to nerves or tendons. Dressings on individual fingers may be kept in place by a cylinder of adhesive tape, with the adhesive side outwards, placed along an uninjured part of the finger before the dressing is applied.

SERIOUS WOUNDS

First concern is control of bleeding which, in 90 per cent of cases, is achieved by direct pressure on the bleeding area. Then treat or prevent development of shock: elevate feet; maintain body warmth; morphine; oxygen inhalation if available.

Dr. Hoffman is with the Civil Service Health Division, Department of National Health and Welfare, Ottawa.

Soft Tissue Injuries

In injuries with intact skin, such as bruises, sprains, strains, our primary aim is to prevent swelling due to edema or gross bleeding into the tissues. Circulation through the region is diminished and swelling inhibited by: elevation of region, if a limb; cold compresses; pressure bandage.

After 48 hours switch to heat and as much free movement as can be tolerated without causing additional injury. Early movement is especially important in joint areas, if bone damage is absent.

Fractures

Avoid further damage by immobilization "where they lie" without manipulation. Splints can be improvised in many ways—e.g., tongue depressor as finger splint; pillow strapped firmly around fractured forearm or leg; opposite leg in fractures of lower limb; and so on.

In compound fractures cover the wound immediately with sterile gauze. Anti-shock treatment given routinely.

Burns

The same principles apply as in treatment of wounds with modifications due to the nature of the tissue injury.

First degree burns: Slight injury to superficial vessels which dilate and produce erythema.

Second degree burns: Damage to vessel walls allowing escape of serum from blood vessels into skin layers resulting in blisters.

Third degree burns: Where superficial tissue layers are destroyed.

Fourth degree burns: Extensive charring.

The burned area should be cleaned under aseptic conditions with green soap and sterile saline. The distress of this procedure may be lessened by first applying 5% novocain solution as a compress for 5 to 10 minutes. Foreign matter and dead tissue should be removed. Apply sulfathiazole emulsion freely; cover with fine mesh gauze or vaseline gauze; bandage; layer of cotton or cotton waste; outer bandage.

All materials used should be sterile. Immobilize the part and leave for from 5 to 14 days if free of infection.

General treatment is most important especially in children. It starts with standard anti-shock therapy and includes plasma administration. It is recommended that all burns be treated fully even though first inspection suggests they are minor.

Chemical burns are treated in the same fashion after free irrigation with copious amounts of water or saline to remove all traces of the chemical.

Tense painful blisters which develop —e.g., on fingers—may be drained under rigid aseptic conditions after 48 hours and redressed.

Yaws Control

A campaign has been launched in Thailand by the World Health Organization to bring yaws under control. Yaws is reported to affect at least 200,000 people in all parts of Thailand. It is estimated that four-fifths of those suffering from the infective stages of the disease are persons under 18 years of age and women of child-bearing age.

Yaws is an infectious, non-venereal disease occurring in the hot moist tropics. It is caused by *Treponema pertenue* and is characterized by an initial cutaneous lesion, the mother yaw, followed by one or more crops of multiple, papillomatous, raspberry-like lesions of the skin. Occasionally late destructive lesions occur involving especially the skin and bones. The spirochetes gain entrance through the skin. Flies may be vectors.

The main function of WHO is to assist in training teams of Thai health workers who will endeavor, by systematic house-to-house visits, to discover all existing cases and to ensure the administration of penicillin to the infected persons.

—WHO Public Information Office

Lyle Creelman *Writes . . .*

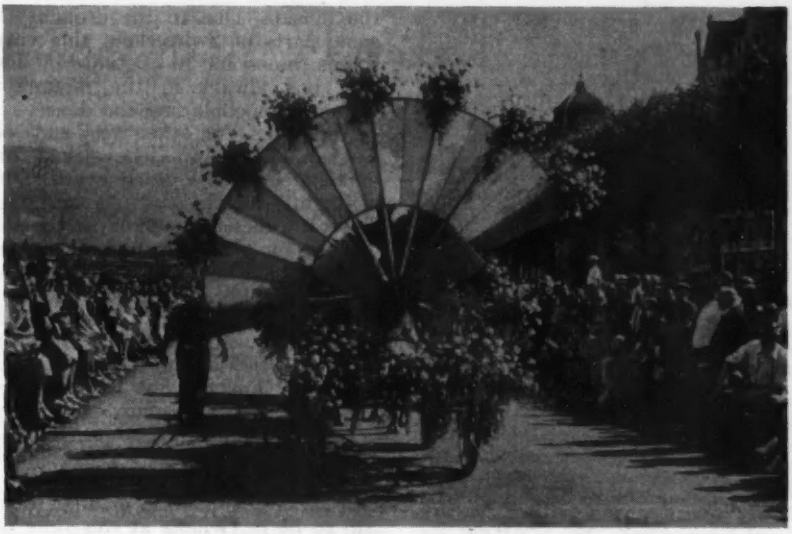
Average reading time — 5 min. 48 sec.

FOR THE FIRST TIME nurses were on the program of the International Congress of Pediatricians which was held this year in Zurich July 24-28. It was attended by over 2,000 pediatricians from all parts of the world. Many scientific papers in relation to newer developments in pediatric practice were presented. A few were devoted to the social aspects of pediatrics and it was in this field that nursing appeared. Miss Una Robertson from New Orleans, who is at the moment a short-term consultant for WHO at the Ecole de Puériculture in Paris, spoke on "The Teaching Role of the Nurse in the Pediatric Ward." Miss Häcler from Switzerland had as her subject "The Nurse's Task in the Care of Premature Children." I spoke on "The Role of the Public Health Nurse in the Prevention of Infant Mortality." We were all limited to 10 minutes. As there was no translation, not all of our audience could understand each of us. It was an opportunity which we welcomed, nevertheless, and we hope that in future congresses of this sort the nursing aspects of medical care will be included.

Dr. Dorothy Nyswander, member of Expert Committee on School Health; her husband, Dr. George Palmer; Helen Martikainen, chief, Health Education, Public Section, WHO.

Following the Congress, there was a special program for nurses, attended by about a hundred, of whom 30 were from countries outside of Switzerland. Miss Fernande Riverin, of Montreal, represented Canada These "Nurses' Days" were sponsored by the I.C.N. and the Swiss Nurses' Association. The first afternoon the emphasis was on nursing education and clinical supervision. Professor Sir James Spence, of Newcastle, gave a very provocative paper on "Co-operation Between the Doctor and the Nurse in Pediatric Service." I hope this will appear in our *Journal* so that you can all have an opportunity to read it. I would advise those who are interested in pediatrics to read any publications of Professor Spence. He is doing very interesting work in his field. Following his paper, a demonstration of clinical supervision was presented by a head nurse, a clinical supervisor, student nurses, and a young patient. The theme of this demonstration was carried through to the next morning when public health nursing was featured. To demonstrate the work of the public health nurse, there were scenes in which the student from the hospital was shown making a home visit with the public health nurse (to the home of the young patient who was, of course, already discharged). She was also shown participating in a child health conference. The use of clinical supervisors is just beginning in Europe and, as at home, provision is not made in many schools for student nurses to participate in home visiting and child health conferences as a part of their basic preparation.

Just a word about the city of Zurich itself. Its history goes back to "the third millenium before Christ.

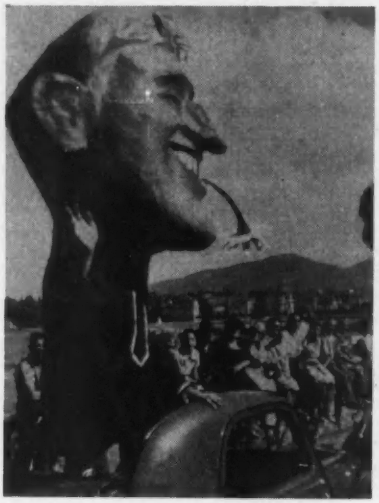


One of the flower floats in the Geneva Fête.

After the glaciers had retreated to the Alpine massif, pile-dwellings arose in the inlets of the lake, where fish were abundant, and their occupants lived above the water throughout the Stone and Bronze Ages, until about 800 B.C." Today, Zurich is the largest and most cosmopolitan city in Switzerland. It has lovely shops with most attractively dressed windows. To me, its charm lies in the old part of the city, with its narrow streets, its twin-towered Grossmünster built about 1100 A.D., St. Peter's Church, with the largest clock-tower in Europe—it was built in the thirteenth century—and, most attractive of all, the Rathaus, which is built on the water's edge. All of these buildings are illuminated at night throughout the summer season and along the streets there are many delightful sidewalk cafés where one can stop for coffee or drinks and remain the whole evening, just chatting and watching the world go by. Frequently in the background there is most delightful music, played by accomplished European musicians.

The week following the Zurich Congress, a seminar in social pediatrics was held in Geneva. This was planned for pediatricians on UNICEF fellowships. We were permitted, however, to invite 10 nurses to participate. As so frequently happens in such a seminar, there were too many speakers and not enough time for discussion. There is still much study needed in conference techniques but, as you can well imagine, the problems are greatly magnified when planning a group discussion in which several languages are involved.

To round out the professional field of pediatrics, the following week we had a WHO Expert Committee on school health. At this meeting, we were privileged to have Dr. Dorothy Nyswander, known to many Canadian public health workers through her book "Solving School Health Problems." Nursing was represented on this committee by Miss Lindquist from Sweden. We discussed health services for the school-age child and tried to remember that our report should be helpful to countries such as Canada; to countries where there are more doctors than nurses; to those where there are no doctors or nurses at all for school work; and where there are not even schools. It wasn't easy!



More of the Geneva Fête parade.

Along with this series of professional activities, you will be glad to know that we also took part in some of the August festivities of Switzerland. Just as we celebrate July 1, so the Swiss celebrate their Confederation on August 1. Its origin goes back to 1291 when the three original cantons—Uri, Schwyz, and Unterwalden—drew up a document, written in Latin and referred to as the Eternal Alliance. It was the foundation of the Swiss state of today which now comprises 22 cantons. On August 1 every year bonfires are lighted on the mountains. Woodsmen collect their wood and each one tries to reach higher ground than the other. It is a lovely sight, from a boat on the lake, to see those fires burning far up on the hillside. Due to the drought in some parts of Switzerland this year it was impossible to celebrate in this way but always in the mountain villages the people sing and dance.

And then, on the week-end of August 11 to 14, Geneva had its famous fête, also a yearly event. The highlights are the costume and the flower parades. This year the parade was led by a chariot drawn by four spirited bay horses and driven by "Roman soldiers." Joan of Arc, mounted on a black charger and followed by warriors in real coats of mail, was also in the parade and so was Don Quixote. The flower floats were magnificent, many of them drawn by beautiful white horses. The Swiss people are very original and artistic and anyone planning to visit Switzerland should arrange their trip to be in Geneva at this time of the year. On the Saturday night there was a 35-minute display of most elaborate fireworks and on Monday, to close the fête, the famous Carabinieri Band from Rome gave a concert, featuring classical music.

I nearly forgot to tell you about the "Bataille de Confetti" which follows every fête parade. This involves real group activity! Everybody buys special sacks of confetti which are on sale for one franc (about 25 cents). They parade along the section of the street closed off for the fête, throwing confetti at everyone they meet. The object, of course, is to catch someone laughing and with a wide open mouth! Very soon you find yourself buying another sack of confetti. It is a lot of fun and recommended as a good mixer!

Hearing Impairment

Because some 10 per cent of all school children suffer some impairment of their hearing and because certain of these conditions can be alleviated by a relatively simple form of radium treatment, Dr. Samuel J. Crewe, Adjunct Professor of Laryngology and Otology at Johns Hopkins University, proposes to test the practicability of a deafness prevention program in lower schools. The present project will test 1,000 Baltimore school children in order to determine whether radium treatment is both effective and economical enough to be recommended for routine usage in regular school health programs.

—U.S. Public Health Service

Institutional Nursing

We Were Skeptics

SISTER PAULETTE FORTIER, S.G.M. *and* MARY O'HARA

Average reading time — 6 min. 24 sec.

THE GLARE of the ceiling spot was playing strangely on the operative field. The surgeon's hands looked tired and once more his penetrating eyes lifted an apprehensive glance at the clock . . . Two and a half hours since the first incision! But there would be only a few minutes more to go—he seemed to brace himself with this thought. The drainage tube had been secured in the large pleural cavity—now they were putting in the intercostal sutures.

A glance at the patient assured the surgeon that his breathing was not too labored, his color not too ashen, though he had lost a fair amount of blood. From the look of things everyone would survive the ordeal—everyone usually did—but for both of us these dreaded sessions meant a great deal of worry, sleepless nights, and what not. They were closing the skin now with interrupted silk sutures. A terse "Cut this shorter" and it was all over.

"Good work!" The words echoed in our ears; we drew a long breath, in fact the first long one we had had time for all morning. The surgeon stripped off his rubber gloves and walked out with his assistant and the medical attendant.

The atmosphere of the room was still emotionally tense . . . whatever it lacked in sweetness it certainly made up in stress; for pneumonectomies and lobectomies by the clever but at times irascible chief of staff were not humdrum affairs!

Drapes came off fast now. Time was at a premium to get the patient back to the ward and into the oxygen tent. This was one of the numberless and important factors—to get the patient in the tent for ample oxygenation of the remaining lobe and the good lung. We always felt relieved after that.

From Room II, where we worked quickly and quietly, we could hear the chief's voice ringing out as it always does: "Lower and lingual lobes removed in the usual manner. Stump buried in the upper lobe. Closure in layers."

He was still sitting on the chair near the stenographer's desk signing operative reports when we came out of the room—he turned towards us, paused a moment, then said: "I'll do another one on Thursday". . . our hearts missed a beat—this was Tuesday; in two days, another one! With a quizzical smile he added: "You know, some day these lobes will be as easy to remove as an appendix." Such a blunt statement left us amazed. We hardly knew what to say. We just nodded dubiously; what else could we do? Then we asked for the diagnosis and booked the operation for the appointed day.

This meant more lost sleep over the difficulties we were bound to encounter. It also meant more planning for improvement of our techniques. There is always the gleaming goal of perfection just ahead for anyone working in surgery and we always try to attain it.

Thursday morning came around. We were ready—at least we thought we were! Our patient was a heavy woman in her late fifties. The surgeon had gone through the usual

Sister Fortier and Miss O'Hara provide an efficient surgical team at St. Paul's Hospital, Saskatoon.

ritual of scrubbing meticulously, donning gown, and he was thrusting his powdered hands deeply into the rubber gloves which were held for him and still we did not have the patient in the exact position!!! We tried to look composed and matter-of-fact while struggling to place her properly but we were intensely conscious of impatient eyes watching us above a tight blank mask. Finally it exploded—"Don't you know by now that the patient must come down the table another inch? You have both done this time and again". . . and the succeeding words were lost in his mask . . .

A few minutes later the neat, long, curved posterolateral incision was made; the muscles rapidly divided, the seventh rib resected, and the parietal pleura promptly incised along the extent of the incision.

With the rib spreader in place, excellent exposure is obtained. We could see the left lung rise and fall against the chest wall. Spot-lights were quickly adjusted to suit the surgeon and gleaming instruments were slapped into outstretched gloved hands on the split second. The patient, under intratracheal inhalation anesthesia of cyclopropane and oxygen, was breathing away nicely while new life poured into her ankle veins from two citrated blood flasks hanging from a pole.

We were now well in the danger zone—and our patient's life entrusted to the expert hands of our thoracic surgeon. Everyone worked with automatic intensity, with the nervous promptness of a team that is prepared for anything. This, indeed, was a tough case and gave us, the two most skeptical of the group, plenty of cause to wonder and worry.

The following afternoon we went to the patient's room, peered intently into the oxygen tent, and what we saw there made us logically conclude that "her hour just hadn't come." Our one-day-old lobectomy was resting comfortably with a broad smile on her face. That was several years ago.

Today, under the same brilliant cone of light, the same dextrous hands perform the same skilful work but under totally different conditions. It is also with an entirely different frame of mind that the same supervising team prepare the theatre.

During the years we have made case studies and improved our planning. Alert to suggestions and cognizant of changes in technique that have resulted in many ameliorations, we have gradually planned and improved our techniques and set-ups to the point where it is a pleasure now, not a nightmare, to go through an operation. Even the atmosphere is clipped of its tense and dramatic suspense. The terrific strain has given place to a breathless happy experience.

There is ease now around the operating table and hardly a terse remark. "Scalpel—sponge—forcep—ligature—scissors—" is all that can be heard to break the silence. Everyone seems to have that calm and collected attitude that comes with experience and confidence, even though at times the patient stands on the brink of death.

It is a worthwhile experience to have lived through moments like those of years ago and those of today. We didn't get a single grey hair over the entire period either, but that was sort of a miracle. Yes, we believe in miracles even in this age where faith seems so weak and rare. Now these cases are just "another operation." Patients come from every corner of the province and from many other points of the country, eager to be cured of their bronchopulmonary diseases.

Just the other morning, a 12-year-old boy was relieved of his left lower and lingual lobes in 45 minutes! In a fortnight he will be back home enjoying normal life again. Shock is minimized with speed like that and recovery is a certainty.

It was precisely after a case similar to this that a triumphant gleam came into the chief's eyes as he looked at us—a gleam that seemed to say: "I told you they would become as simple as removing an appendix." We couldn't help but smile at this great surgeon as though we were pretty

proud of him (and we were!).

In summer, elective time for this type of chest surgery, school age boys and girls afflicted with bronchiectasis come to be cured of their incessant tiresome cough—this ailment that drains all their energy. These children usually look forward to the operation; therefore their psychological adjustments are remarkable. For them it is simply the last step before their return to health and play and happiness.

Adults have just as good results only convalescence is longer. It always surprises us to see how little stress they go through following surgery. In fact, the mortality of partial pneumonectomy is less than 5 per cent, in recent years, in good-risk patients.

Naturally, to achieve these striking results several factors are a *must*. These prophylactic measures before operation include: Several weeks of rest; treatment with streptomycin and penicillin aerosol; study of their bronchial tree with iodized oil; pneumothorax in certain cases and bronchoscopies. The anesthetist has to be a well-qualified and thoroughly competent individual to enable him to cope with the different problems he will certainly meet. Last and not least of the requisites is access to a good, well-equipped operating room with an adequately trained graduate staff.

Our thoracic surgeon is performing a difficult task in a modest and unostentatious manner and is making a substantial contribution to the welfare of those suffering from surgical disease of the chest.

In Memoriam

Elizabeth Anderson, who was a well known nurse in Ottawa for many years, died there on August 13, 1950, in her 90th year following a brief illness. Miss Anderson returned to Ottawa to practise following her graduation from Syracuse (N.Y.) Memorial Hospital many years ago.

* * *

Norah T. Christie, who graduated from the Montreal General Hospital in 1932, died in Montreal on September 11, 1950. Miss Christie had been active in nursing until recently.

* * *

Mary C. Johnston, a graduate of the Hamilton General Hospital, died in Toronto on August 19, 1950, in her 83rd year. She had practised in Toronto but had been retired for some years.

* * *

Annie (Craig) Kelly, who graduated from Chatham (Ont.) Public General Hospital in 1901, died recently.

* * *

Zella Marcellus, who had practised her profession in Ottawa since graduation, died suddenly on August 17, 1950, at the age of 25.

Agnes (Parley) McDowell, who graduated from Chatham Public General Hospital in 1933, died on April 11, 1950. For several years prior to her marriage, Mrs. McDowell practised private nursing. She was night supervisor at the Chatham Hospital for a time.

* * *

Edna Orr, who graduated from the Chatham Public General Hospital in 1928, died on September 5, 1950, after an illness of four months.

Wolfe, Chatham, Ont.
EDNA ORR

Following post-graduate training at Grace Hospital, Detroit, and the Ottawa Civic Hospital, Miss Orr was operating room supervisor at the Chatham Hospital. In 1941 she enlisted in the R.C.A.M.C., going overseas with No. 2 C.G.H. She saw service in England, France, Belgium, and Germany. Returning to Chatham, Miss Orr took over the reorganization of the medical records department, where she was in charge until her illness intervened.

* * *

Louise (Steel) Parker, who graduated from the Peterborough Civic Hospital in 1918 and later was superintendent there, died on August 19, 1950, at her home in Agincourt, Ont. Mrs. Parker had also held positions of responsibility in several U.S. hospitals prior to her marriage.

* * *

Jessie Margaret (Peele) Richmond, a graduate of the Royal Columbian Hospital, New Westminster, died on August 23, 1950, after a long illness.

* * *

Annabell Ross, who graduated from the Chatham Public General Hospital in 1905, died early this year.

* * *

Letitia (Jones) Van Dusen, a graduate of the Toronto General Hospital, died in Toronto on July 24, 1950, in her 91st year after a short illness. In addition to private nursing, Mrs. Van Dusen had served as superintendent in hospitals in Montreal and New Jersey. She had retired at the age of 70.

* * *

Agnes White, a graduate of Aberdeen Hospital, New Glasgow, died on August 2, 1950, at the age of 75. Miss White had served as superintendent of Highland View Hospital, Amherst, for several years. After service overseas during World War I, she was supervisor of Murray Hill Hospital in New York.

Debunking the "R" Months

Oysters are edible the year around. They are fatter, more palatable, and more plentiful on the market during those months which contain the letter "R". The tradition that oysters must be eaten only in the "R" months may have originated somewhat as follows:

1. In that species of oyster eaten in the Old World for centuries, fertilization of the seed from which the baby oysters grow takes place within the shell of the parent oyster. Shortly before the baby oysters are ejected by the parent to fend for themselves, they begin to develop a shell. If the Old World oyster is eaten at this stage of incubation, the large number of almost microscopic baby oysters, each developing a shell, impart a gritty quality to the meat. Because the reproductive period of all oysters is in the summer, early settlers of this continent, cognizant of this but mindful of their Old World variety, avoided placing New World oysters on the menu until later in the year. It is only coincidental that these months in which the oyster is most palatable happen to be the "R" months.

2. Even after our forefathers discovered that the North American East Coast oyster fertilizes its eggs in the sea water outside the parent shell, oyster consumption continued, for the most part, to be a winter activity. Partly responsible for this was the fact that only in recent years have refrigeration facilities been developed whereby oysters can be preserved in warm weather while being transported from the coastal growing areas.

3. Today, when perishable food products are transported thousands of miles by railroad and airplane, yet preserved by refrigeration, the greater portion of the country's shellfish consumers still clings to the old tradition. The advent of quality frozen oysters available throughout the year, however, may change this custom.

—U.S. Public Health Service

In women of 65 years of age and older, falls are responsible for three-quarters of all accident fatalities. Impaired vision and hearing, weakened skeletal muscles, and other physical deterioration make the aged prone to falls. Moreover, accidents of this kind, which ordinarily cause little disability at the younger ages, often result in serious injury or death in older people.

—M.L.I.C. Statistical Bulletin

Public Health Nursing

The Teacher-Nurse Team

DOROTHY B. MARSHALL

Average reading time — 8 min. 48 sec.

ROBERTA'S PROBLEM belonged to her school teacher and nurse. Roberta was a rather tall, thin, nervous child and had been a new Canadian for nearly two years, having been born in Scotland. She was five years old and had been a student for four months under a young kindergarten teacher in a Winnipeg school when I met her as the school nurse for the first time. I had come to the school after the Easter holidays. Roberta's problem revealed itself when I was completing a class health examination of skin and tonsils. It was the second examination for these children and the pretty young teacher told me quietly before I started that there might be an outburst from one of them. She had prepared the class for my visit and hoped everything would go smoothly.

I could see tears in Roberta's eyes and a worried look on her face as she approached me. I reassured her and she let me examine her hands and arms. When I asked if I might see her teeth, she put her hands up to her face and burst into sobs. The teacher took her to one side but no amount of coaxing would persuade Roberta that the nurse's looking was just part of a plan to make sure every boy and girl had "clean hands, teeth, and hair."

A subsequent private conference with the teacher revealed that this had been Roberta's performance when the former nurse had made an appearance. Further, whenever the teacher had given simple talks on health habits to her class, she had received stiff, formal notes from Roberta's mother saying that "her daughter's health was her responsibility and not the teacher's. Would she mind teaching her child something constructive, instead of just having her play on paper?"

The teacher had invited Roberta's mother to pay her a visit but she had only visited the principal who had tried to explain the program carried on by the kindergarten teacher. There still seemed to be questions and conflicts unanswered which were not healthful for Roberta's own mental hygiene in her family set-up. Consequently, the nurse agreed to make a home visit to gain more understanding for herself and the teacher.

The first visit was helpful in revealing Roberta's mother as a middle-aged Scottish lady of good intelligence who had been twice married. She had one son Richard, 12 years old, by her first husband who had been killed in the raid on Dieppe. She had been very happy in her first marriage and Richard seemed to be getting along well in school. Roberta was the daughter by her second husband, a Canadian soldier a few years younger than his wife, whom she had met and married a year after the death of her first husband. She had had many expectations when her husband suggested they return to his home in Winnipeg, following his discharge from the army. I gathered they had not all been fulfilled. The uncertainty of her husband's job with a meat-packing plant, the monthly payments to be made on a new home, the difficulty she was having in making friends in a new country, and the

Miss Marshall is a staff nurse with the Winnipeg Health Department.

differences in the schooling of Canada and Scotland were causing conflicts that would affect anyone with her rather dour Scottish outlook. I did very little more than listen at the first visit but I did try to interpret the teacher's and the school nurse's role with her child. When I left after the visit the mother extended me a cordial invitation to call again.

The difference in early school training between Scotland and Canada accounted for a lot of misunderstanding in the work Roberta was taking home to her mother. I felt the mother had only a fair appreciation of the fact that Roberta needed approval of her "little bits of work." She was also jealous of her daughter's affection for the kindergarten teacher. The incident at the class health examination had occurred because of the conflicts that were being built up inside Roberta whenever her mother would voice in strong terms what she thought about the health talks that were given to her in school by the teacher and the nurse.

Through teacher-nurse conferences, we gained more insight into Roberta's problem. Together we planned, along with several of the nurse's visits to the home, how we could make Roberta's mother more aware of her daughter's needs and what the Canadian school system offers to each child. The teacher now receives cordial notes from the mother, the nurse is considered a family counsellor, and Roberta is on the road to happier mental health.

For me, Roberta's problem had crystallized how the teacher and nurse can work together for the betterment of each school child. This team was the theme of a talk I had the opportunity to give before a summer training group of kindergarten teachers. My material was gleaned from current school health books, nursing journals, child health literature, and suggestions from nurses and teachers who had been longer in the field. I found that my discussion was enriched by additions from my audience—sometimes a difference of opinion, sometimes a helpful, practical suggestion. One quarter of the teaching group came from rural points and I had to temper my statements to suit their needs. Briefly, these were the points covered under the five divisions of the discussion.

Healthful School Environment

The school nurse is always present as a counsellor to guide the teacher in the most healthful use of her classroom. When the teacher has the good fortune to be asked to supervise the arrangement of fixtures in her room, it will be to her advantage to have toy cupboards built for the use of the children and clothes-lockers or hangers for their individual heights. Certain colors on walls reflect more light than others and the teacher can help to arrange children at windows when doing close work to give them the maximum amount of light. Everyone who is responsible for the safety of the child should be alert to the fact that the school environment includes the whole school, playground, parks, streets and intersections where children may travel.

Recognition of Physical and Mental Disease

The teacher, constantly observant of her class, can be most helpful in detecting the child with an unusual physical or mental state who should be reported to the nurse. I showed the group the informative, well-illustrated booklet, published by the Metropolitan Life Insurance Company, entitled "What Teachers See." This gives pertinent descriptions of common childhood diseases and conditions. I pointed out how diseases occur by seasons among school children:

Sept.-Oct. —Signs of skin disorders.
Nov.-Dec. —Signs of cold, tonsillitis, scarlet fever, and other communicable diseases.
Jan.-Feb. —Signs of measles, whooping cough.
Mar.-Apr.—Signs of chickenpox, mumps.
May-June—Signs of skin diseases and sunburn.

This seasonal incidence would vary from district to district.

I felt that the teacher could easily be the key person to detect a child with a visual or hearing defect. Many of the kindergarten children do not have medical examinations prior to their school entrance and the mother may mask her child's defect in her care of him. The teachers contributed to my few sentences about the observation of the child with unusual symptoms of emotional tension. They all felt that each child showed varying emotional symptoms at the beginning of the term, as they were learning to give and take.

Definite Program of School Health

The health program, as with any other school plan, should be integrated into all activities—flexible, seasonal, and practical. I have found a simple plan is to work a program suitable for each month:

Sept.—First aid procedures; safety rules for school and streets; teaching of basic health habits; explanation of nurse's duties.

Oct. —Teaching in prevention of colds—i.e., use of proper amount of clothing, fish oils; importance of diet.

One of the practical suggestions for health teaching on which I commented was the daily class health inspection. I advocated it as the duty of the teacher to make some type of health inspection every day in order to screen the child with infection. For the pleasure of the children it should be varied. It is often a splendid opportunity for incidental health teaching. Many of the teachers added refreshing ideas they had gathered for these inspections, such as races and inspection of the children by one of the class who acts as nurse or doctor.

I suggested that children could be shown the value of water and sunshine through watching plants grow. Many of the teachers had used this idea successfully.

The observance of safety rules for street crossings could be the objective of a class field party to watch a street corner where a policeman was on duty. A mock street scene could be a practical play experience in their classroom.

Health habits can be taught through discussion of the habits of the new baby or pet animal that has arrived in one of the children's homes.

I explained that it was not the duty of the nurse to supplant the teacher in her health teaching but to reinforce what she said. The nurse was usually on hand to help the teacher with additional health literature or timely posters for the particular health project that was being carried out.

Teacher and Nurse Cooperating

This side of the teacher-nurse team is important enough to warrant a separate division. There are many ways in which this cooperative spirit can be built up. In order to help understand the school child and his problems, the teacher and nurse contribute those pertinent details which assist in rounding out the picture of the child in his background. The nurse is able to make her home visit with an adequate knowledge of the problems and is able to offer suggestions that have been worked out jointly with the teacher. Opportunities for frequent teacher-nurse conferences build up this cooperative spirit. Through them, the nurse reveals to the teacher the children's defects discovered at medical examinations and any limitations which these defects may place on the child. An interchange of professional literature between the teacher and the nurse gives each a better understanding of the other's work.

Importance of Healthy Teacher

The nurse is interested, too, in the health of her teachers. They both know that the teacher who will give most abundantly to her class must be vitally healthy. All the maxims for good health are essential to the teacher plus a few special ones:

1. An adequate convalescence following illness.
2. Striving for mental relaxation in interests and hobbies that will let her

associate with those not in her professional group.

Finally, where there is a proper appreciation by the teacher and nurse of what each is trying to do, it follows that there will be a better understanding of the school children and their needs. Individual problems, such as little Roberta's experience, have more chance of a happy solution by the cooperative work of the teacher-nurse team.

In the Good Old Days

(*The Canadian Nurse, November 1910*)

"While serious fires are not common in hospitals . . . every hospital should have a fire-drill instituted and it should be practised often enough to be well in mind. It is useless to include in this drill the average servant, who comes and goes with such regularity, but it should take in the engineers or night-watchmen (who are apt to be more or less permanent) and the nurses. Some institutions have used, instead of the regulation drill, a lesson to be learned verbatim and recited as often as once a month."

* * *

"A very large number of the mistakes which nurses make are the result of their having been insufficiently taught. It seems axiomatic that a nurse should not be allowed to do a thing unless she knows how; yet over and over we permit accidents to happen from the violation of this principle . . . We excuse ourselves for these occurrences by the plea that we are short of nurses and lack the time to give instruction. This is a chronic state of affairs in most hospitals."

* * *

"An impressive service in commemoration of the late Florence Nightingale, O.M., (who died on August 13, 1910), was held in St. Paul's Anglican Church, Toronto."

* * *

"*The Canadian Nurse* Editorial Board is now an incorporated body . . . This step places us in a better position to properly and regularly carry on the work incidental to the publication of *The Canadian Nurse*—that magazine which has come to mean so much to the nurses of Canada and to which the nurses of Canada are so loyal."

* * *

"We congratulate our friends at Edmonton on the coming Alexandra Hospital, the erection of which is now proceeding in the city."

"When I first made known to my friends the fact that I intended taking a post-graduate course, they held up their hands in horror. Wild tales were poured into my ears of the awful things that were said and done to a post-graduate nurse . . . From what I have seen I think that in most cases the bad treatment a post-graduate nurse receives is due to her own actions . . . I have heard several post-graduates complain of the way they were treated by pupil nurses but in almost every case the post-graduate nurse was in the wrong . . . The post-graduate nurse is subject to the same rules as the pupil nurses, while graduates of the school are allowed several privileges as to late leave, laundry, etc."

* * *

"In its war on tuberculosis, New York City has organized a 'day camp' that is at present located on an unused ferry boat. Despite its name, adult male patients are allowed to stay there at night as well as during the day, sleeping on cots on the upper deck in the open air. The women and children are admitted during the day. As tubercular children are now debarred from New York schools, a regular public school is conducted on board the boat. In addition to the regular studies, the pupils have special lessons in hygiene, cleanliness, diet, breathing, etc."

Tolerance means we should not expect too much of other people. One of the commonest mistakes is expecting people to be reasonable. Yet few, if any, people will always be reasonable from our standpoint. To put it another way, our viewpoint will not always seem reasonable to other people. We will save ourselves many disappointments if we *do not expect people to be reasonable.*

—K. C. INGRAM

Aux Infirmières Canadiennes-Françaises

Service Social à l'Ecole des Infirmières

GENEVIÈVE LAMARRE

Average reading time—11 min. 12 sec.

C'est d'une idée nouvelle que je veux vous entretenir, idée que des circonstances particulières m'ont suscitée et qu'une expérience, assez récente d'ailleurs, m'a permis d'apprécier. Il s'agit du Service Social à l'École des Infirmières.

On a défini le Service Social: l'art d'adapter l'individu à son milieu et le milieu à l'individu.

La transplantation subite de l'étudiante au milieu hospitalier est un fait. Les problèmes que cette transplantation même soulève sont connus de chacune de nous, étudiantes d'hier, et particulièrement du personnel de l'école, témoin quotidien des situations de l'étudiante infirmière.

Quels sont ces problèmes? D'adaptation d'abord.

Adaptation à l'école: Milieu nouveau où l'étudiante rencontre un mode de vie qui ressemble vaguement à celui du pensionnat: horaire, vie en commun, cours, etc.

Adaptation aux compagnes: Passe encore pour le contact avec le groupe des probanistes dont elle est. Mais il y a les aînées, élèves de 2ème et 3ème année, qui volent déjà de leurs ailes et que l'activité journalière tient un peu éloignées d'elle. Pour les comprendre, se les expliquer, il faudra le temps—ce grand maître. Mais entre temps, que d'étonnement, d'interrogations! Un commun idéal a rassemblé les autres depuis quelque temps déjà, mais peut-on dire qu'une affinité de caractère les unit invariablement?

Adaptation à l'hôpital: Cet édifice, ces longs corridors, ces portes micloses d'où s'échappent ronrons, souffles, soupirs, et plaintes; ce va-et-vient, tous ces uniformes et costumes divers: l'officière, l'infirmière, l'étudiante, le médecin, l'étudiant, l'infirmier, les aides, les employés de service, les visiteurs—tous ces gens passent.

Et les choses qui passent aussi: civières, chariots, chars à pansement, odeurs . . .

Adaptation aux patients: Ces gens qui souffrent, ceux que la maladie retient, ceux qui circulent. Et lorsque l'étudiante a bien ouvert les yeux, pris contact avec le souffrant; il vient l'adaptation à la souffrance, la compréhension du malade, de ses besoins, et de ses états d'âme.

Adaptation au personnel: Du côté de l'école, du côté de l'hôpital. Que de relations subites et variées, mais pas nécessairement toutes faciles et heureuses.

Adaptation à elle-même: Hier libre, aujourd'hui consacrée, "marquée d'un signe spécial, celui de dévouement. Hier jeune fille, aujourd'hui messagère de santé, d'espoir de guérison. Éduquée et éducatrice, apôtre de paix sociale, agent de liaison charitable entre les libéralités et les détresses."

Quels sont encore ces problèmes auxquels se heurte l'étudiante infirmière? Ce sont les difficultés inhérentes à notre lot humain. Elles sont:

D'ordre personnel: Bien intimes, ces difficultés originent d'abord du fait de sa vocation, de ses responsabilités nouvelles. Puis il reste toujours "le vieil homme," les conflits personnels, les conflits émotifs, sentimentaux, les forces qui cèdent.

Mlle Lamarre est directrice des études, l'Hôpital de l'Enfant-Jésus, Cité de Québec.

D'ordre familial: Transplantation disions-nous au début, mais plutôt bouture ou mieux marcotte. Le rameau tient encore à la branche-mère. Epreuves et joies familiales, sources de réactions chez l'infirmière.

D'ordre économique: Quelles sont la plupart du temps les ressources de l'étudiante? Elles sont le reflet de la condition sociale et familiale de la région, souvent précaires.

D'ordre social: Rupture ou quasi rupture avec le cercle coutumier. Ajustement, ré-éducation, adaptation à des relations nouvelles.

D'ordre professionnel: Au début de l'entraînement, les appréhensions; durant l'entraînement, la nécessité d'allier la formation scientifique, l'habilité technique, les obligations morales; puis, le problème à répétition de l'orientation: notre étudiante sera infirmière.

Voilà résumés les problèmes divers qu'affronte l'étudiante en son milieu scolaire. N'est-ce pas assez pour vérifier la nécessité d'un Service Social où l'on tient compte de son essence même: adapter l'individu à son milieu et vice-versa? Nous lançons l'idée, sans crainte des retentissements, assurée que nous sommes, que le bien ne fait pas de bruit.

Nous ne tenterons pas de préciser les cadres; ce serait vraiment trop ronflant pour 1950. Nous nous bornerons à un exposé simple de ce qu'il nous a été donné de réaliser. La travailleuse sociale, comme l'infirmière, réalise quotidiennement sa vocation. Elles ont certainement un but commun: le service à autrui.

Appelée à la direction des cours d'une école de gardes-malades, comme infirmière, nous ne nous sommes pas départie de notre formation de travailleuse sociale. Le prochain nous presse encore. Les problèmes se sont présentés aux étudiantes et les étudiantes à nous.

Sans affichage, nous avons reçu les élèves, nous avons utilisé nos techniques générales du Service Social, en les adaptant. Nous les avons associées aux méthodes d'éducation.

Il n'a jamais été question d'heure fixe pour les entrevues. Le travail s'est souvent révélé fructueux à cause de la facilité de connaître le problème et le milieu: le problème et le milieu nous étant très familiers. Nous n'avons eu par ailleurs, aucun mérite à établir nos contacts; la compréhension de nos collaboratrices ne nous a pas été accordée sous le titre officiel de Service Social: l'esprit seul y présidait.

Pour illustrer le travail que nous avons tenté de réaliser, nous mentionnerons une ou deux histoires de cas.

Mlle V., élève de 1ère année, rate un test. Nous lui imposons la reprise. Elle accepte bien mais nous laisse voir un peu de panique devant cet échec scolaire. Le lendemain, lors d'une rencontre, elle veut parler sa gorge s'étrangle—"Je ne suis pas intelligente. Je ne fais rien de bien. Ca ne va pas non plus au département." Cette jeune étudiante, grande, pâle, jolie, à l'expression un peu triste, mais pure, nous raconte qu'elle développe un complexe d'infériorité depuis l'âge de huit ans, alors qu'elle reprit la classe après une absence due à une pneumonie. L'institutrice d'alors lui reprochait de n'être plus intelligente parce qu'elle ne rattrapait pas le rang qu'elle tenait avant la maladie. La mère, de son côté, lui faisait souvent la remarque qu'elle n'était plus aussi intelligente qu'à l'âge de sept ans.

Au département, elle redoute la surveillante, tant elle s'imagine inférieure et de fait les gaffes se multiplient. Elle pleure, cyanose, ne peut plus retourner aux soins des malades, ne peut s'expliquer avec son officière. Nous l'assurons que se mesure intellectuelle n'est pas donnée. Nous lui soulignons sa faiblesse nerveuse, lui recommandons de voir un médecin et d'aller exposer son cas à la directrice de l'école qui est, en somme, la mère spirituelle des élèves. Elle s'oppose, avouant la craindre, nous lui proposons de se reposer au lit. Nous faisons de l'air, couvrons l'élève, et l'assurons que nous irons l'éveiller. Pendant le repos, nous exposons le cas à la directrice et suggérons le transférement de l'élève du département des dames à celui des messieurs où le service est moins harassant et l'officière d'approche moins sévère. L'élève demande une entrevue

à la directrice qui lui permet de s'extérioriser, de se raconter. Le transférement lui est proposé pour équilibrer ses forces; elle suit un traitement. L'élève nous rencontre ravie, souriante, étonnée d'avoir été comprise. Ses succès scolaires se succèdent. Chez les malades, ses soins sont bien évalués; sa nervosité disparaît, son visage est détendu. Chaque fois que nous la rencontrons elle sait sourire et dire sa reconnaissance. Il y a deux jours, elle nous avouait avoir échappé à l'envie folle de partir.

Mlle B., 3ème année, distinguée belle éducation, situation aisée, brillante élève. Infirmière douée dont le perfectionnement pourrait enrichir notre groupe et notre société. Nous causons de spécialisation. Elle se montre piquée, vient régulièrement pour choisir son domaine avec nous. Finalement nous l'orientons en éducation aux Etats-Unis.

De combien d'exemples encore, nous pourrions illustrer notre causerie. Mais le fait est là. Nous recevons les données, faisons l'histoire sociale, posons le diagnostic pour aborder le traitement.

Faut-il avouer la satisfaction qui en résulte; nous ne parlerons pas de celle de l'élève, mais nous ressentons la nôtre.

Une ombre se pose—c'est le manque de temps, cancer social!

Pour une réalisation fructueuse, nous envisageons pour le moment l'organisation du Service Social aux mains de la directrice des cours qualifiés comme l'étude du problème et du milieu.

Nous envisageons aussi la possibilité du succès, dans une répartition de sa tâche de directrice d'études; division du travail scolaire, par la collaboration d'institutrices spécialisées.

Cette innovation nous tient à coeur comme moyen indispensable d'éducation, de cette éducation dont Spalding a dit qu'elle est le développement complet de toutes les forces humaines—forces naturelles, surnaturelles, sociales, vitales, personnelles, et professionnelles.

The Menopause

The menopause occurs in both sexes. It is a means of preservation. In the female the alteration takes place comparatively rapidly; cessation of menstruation is the striking change. The purpose of the menopause is to end the possibility of reproduction, since pregnancy and labor would expose aging tissues to severe physical risks. As usual, a good margin of safety is provided so that 20 to 30 years remain before dissolution ends her usefulness to the youngest possible offspring. In the male, the problem of reproduction incurs no similar risks. Spermatogenesis, therefore, continues, slowly diminishing with age. The associated changes are also gradual and the menopause in the male, though definite, is less impressive—with very rare exceptions.

The lack of "growth hormones" at this time, rather than any change in the vascular supply, probably produces the rapid form of osteoarthritis (and bursitis), with the appearance of painful Heberden's nodes which occur in women. This process has nothing to do with infection or foci of infection. After a temporary disability this affection dies down as osteoarthritis always does and the treatment is on normal lines. Reduction in weight is the most beneficial. In the male quite similar regressive joint changes appear, probably from the diminishing supply of "growth hormones" but, like lessening spermatogenesis, it is a gradual, milder process, without any sudden transformation which, in the female, has earned it the name of "menopausal arthritis."

—Trevor Owen, M.B.

Welfare in Ontario

Approximately 23,000 persons now receive relief in Ontario municipalities and unorganized areas in northern Ontario. This group comprises persons who are mainly ineligible for special forms of assistance such as Old Age Pensions, Mothers' Allowances, etc. Physical disabilities are mainly the reasons for the majority of persons receiving relief at this time. Other major causes include separation and desertion cases.

Nursing Profiles

Another of Canada's outstanding nurses has retired. **Kathleen W. Ellis** relinquished the last of her professional responsibilities this summer and has settled down in her own home town of Penticton, B.C. Miss Ellis reports that she becomes more intrigued each day with the intricacies of housekeeping. Those of us who know her well will understand how thrilled she was to find that her neighbors love a game of bridge. Miss Ellis asked us to extend a cordial invitation to the members of our profession "to visit my home where there will always be a warm welcome and a lovely view, soul-satisfying, if not much else. My garden includes two peach, three pear and a huge apple tree, so no one starves in fruit season and pickers will be especially welcome!"

Of Irish parentage, Miss Ellis journeyed to Havergal College, Toronto, for her high school education. She went further afield for her professional education, graduating from Johns Hopkins Hospital, Baltimore, in 1915. Service with the C.A.M.C. called her soon after. For over a year Miss Ellis was matron of the Vancouver Island Military Hospital. She returned to Johns Hopkins briefly as second assistant in the school of nursing office. Operating room supervisor at the Henry Ford Hospital, Detroit, and second assistant in the school of nursing office at the Toronto General Hospital were the prelude to her assumption of the heavy duties of superintendent of nurses and director of nursing service at the Vancouver General Hospital.

Notman, Montreal

KATHLEEN W. ELLIS

Following her resignation in 1929, Miss Ellis decided to sample public health nursing. She enrolled at Bedford College, University of London, and received her certificate in 1930. The drawing power of hospital administration was strong, however, and upon her return to Canada Miss Ellis accepted the position of director of nursing at the Winnipeg General Hospital. She resigned five years later and returned to university work, securing her B.S. degree from Teachers College, New York, in 1937.

Her interest in professional organization work took a very practical form when Miss Ellis assumed her duties with the Saskatchewan Registered Nurses' Association as secretary-treasurer, registrar, and adviser to schools of nursing. Under her energetic leadership, the interests of nursing education advanced rapidly in that province, culminating in the organization of the School of Nursing in the University of Saskatchewan. Miss Ellis herself assumed the directorship of this school with the rank of professor of nursing. She has retired simultaneously from the association and the university work.

The strains on the fabric of nursing which were wrought by World War II necessitated the appointment of an emergency nursing adviser at our National Office. Miss Ellis was the unanimous selection of the Canadian Nurses' Association to fill this difficult role. Eighteen months later, she assumed the full responsibility of general secretary of the C.N.A., as well as national adviser, for one year. In the fall of 1944 she returned to Saskatchewan.

As she settles down to her less strenuous life, Miss Ellis carries the hearty good wishes of nurses everywhere that she will long enjoy her happy relaxation. That she will be missed is inevitable. Perhaps she will favor us with

periodic appearances at conventions where we can enjoy again both her broad understanding of nursing problems and her exotic hats.

Ruth Catherine Aikin has assumed her new duties as assistant secretary-registrar with the Association of Nurses of the Province of Quebec. Born in Prince Albert, Miss Aikin received her education in Winnipeg and Westmount, Que. She graduated from the Montreal General Hospital in 1938. General staff and private nursing provided useful background experience prior to her entry into the field of industrial nursing with Canadian Car Munitions Ltd., in 1941. Three years later Miss Aikin enlisted with the R.C.A.M.C. and served in Canada before proceeding to England with No. 11 C.G.H.

A desire to broaden her educational background led Miss Aikin to McGill University following her discharge from the services. She received her B.A. in 1948 and her B.N. in 1949. For the past year she has been an instructor at the Montreal General Hospital. Her active, interested, and pleasant personality and incisive mind will add new strength to this busy association.

Van Dyck, Montreal

R. CATHERINE AIKIN

Margaret Murray Campbell, who is assistant director of public health nursing with the B.C. Department of Health and Welfare, was born in Prince Rupert of Scottish parentage. Educated in Vancouver, she graduated from the Vancouver General Hospital in 1941 and received her B.A.Sc. from the University of B.C. in 1942, majoring in public health nursing. In 1949 Miss Campbell received her M.P.H. from the University of Michigan where she was elected to the Phi Kappa Phi Honor Society for her high scholastic standing.

Miss Campbell started out as a staff nurse with the public health service in the Matsqui-Sumas-Abbotsford area in B.C. in 1942. Four years later she became senior public health nurse in Kamloops district, being appointed supervisor in that territory the following year. She moved up to become a supervisor from the central office in Victoria in 1948 and assumed her present position in September, 1949.

Committee work in the R.N.A.B.C. has given Miss Campbell an insight into the many problems that confront professional nursing today. She is a member of the Alpha Omicron Pi Alumnae and of the Soroptimist Club of Victoria. She relaxes at golf and handicrafts and includes care of gold-fish among her hobbies.

Campbell Studio, Victoria

MARGARET CAMPBELL

Isabelle MacLean Reesor has joined the faculty of the School of Nursing of the University of Alberta this autumn after having completed requirements for her master's degree at Teachers College. She is lecturer in public health nursing. A graduate of the University Hospital, Edmonton, Miss Reesor received her B.Sc. in 1942 and joined the staff of the Calgary Health Department. She was the recipient of a Kellogg Fellowship this year which enabled her to make a broad study of public health nursing organization and function. Miss Reesor has maintained her earlier interest in work among teen-age girls. Riding is her favorite pastime.

Evelyn Beulah Moulton who received her B.N.Sc. degree from Queen's University, Kingston, in the spring of 1950, has joined the staff of the School of Nursing there as lecturer in nursing education. Miss Moulton graduated in 1938 from the Ontario Hospital, Kingston, after one year of affiliation with the Toronto General Hospital. In 1945, she received her certificate in teaching and supervision from the University of Toronto School of Nursing and has been active both as an instructor and a supervisor in her own school. Very versatile, Miss Moulton has a wide variety of hobbies, including reading, needlework, cooking, gardening, cycling, and riding. She is keenly interested in church work.

Ashley & Crippen, Toronto

EVELYN MOULTON

Winifred Norquay has taken up her duties as nursing service consultant with the Alberta Tuberculosis Association. A graduate in 1936 of the Royal Alexandra Hospital, Edmonton, Mrs. Norquay engaged in general duty for a couple of years before becoming assistant in charge of the obstetrical unit at R.A.H. During the five years she was associated with this department, she took time out for post-graduate work in obstetrics and gynecology at the Chicago Lying-In Hospital. In 1945, Mrs. Norquay switched to industrial nursing and personnel work with the Great Western Garment Co. in Edmonton. Four years later she enrolled in the course in public health nursing at the University of Alberta. Following graduation there, she took a special course at the Central Alberta Sanatorium, Calgary, in preparation for her new duties. Mrs. Norquay has always been active in her alumnae association and for relaxation turns to golf, riding, and bowling. Her new work will take her to all parts of the province.

Kensit Studio, Edmonton

WINIFRED NORQUAY

Five new supervisors have recently been appointed to as many health units with the Ontario Department of Health. **Helen Elizabeth Etherington,** a graduate of the St. Catharines General Hospital in 1938, who took her certificate in public health nursing in 1942 and in administration and supervision in 1947 from the University of Toronto School of Nursing, is supervisor with the Muskoka District Health Unit. Miss Etherington has worked in tuberculosis sanatoria and has had public health nursing experience with the Toronto Department of Public Health, International Nickel Co., in Chilliwack and Prince Rupert, B.C. She had had three years' experience as a health unit supervisor. Saskatchewan-born **Carrie B. Genik** graduated from the Royal Alexandra Hospital in Edmonton and received her public health instruction in both the basic and senior levels at the University of Toronto School of Nursing. Now supervisor of public health nursing in the Kenora-Keewatin area health unit, Miss Genik has worked in the Niagara Peninsula Sanatorium, as staff nurse with the St. Catharines-Lincoln health unit, and as senior nurse with the Northumberland-Durham health unit in Cobourg, Ont. **Grace Inglis Joyce,** born in Scotland, graduated from Cumberland Infirmary, Carlisle, Eng. She received her basic

public health training at Wayne University, Detroit, the advanced at University of Toronto. Mrs. Joyce had varied nursing experience in the United Kingdom before her marriage. In 1946 she joined the Health Department staff in Windsor where she is now supervisor. **Miriam C. MacDonald** is supervisor of the nursing division with the Prince Edward County Health Unit. A graduate in 1938 of Toronto Western Hospital, Miss MacDonald holds both basic and advanced public health nursing certificates from the University of Toronto School of Nursing. After four years on the staff of the Toronto Department of Public Health, two years in North Bay as senior nurse, and a year in supervisory work at Windsor, Miss MacDonald will now have an opportunity to work in the rural service which she prefers. **A. Mary Pae,** who graduated from the Montreal General Hospital in 1937, also received her public health certificates from the University of Toronto. Miss Pae had wide experience in hospital work before enlisting with the R.C.A.M.C. in 1942. She served three years overseas in England and on the Continent. She had worked in the Brant County health unit before moving up to her present position as supervisor with the Lennox and Addington County unit in Napanee.

MARY E. INGHAM

Mary Elizabeth Ingham is the superintendent of nurses at Victoria Public Hospital, Fredericton. Born and educated in Toronto, Miss Ingham graduated from the Hospital for Sick Children and later secured her certificate in teaching and supervision in schools of nursing from the McGill School for Graduate Nurses. She has had wide experience in institutional work, including head nurse of a surgical ward, operating supervisor, and instructor in her own school; second assistant superintendent of nurses and clinical supervisor at Toronto General Hospital; superintendent of nurses at the Moose Jaw General Hospital; and superintendent of the L. P. Fisher Memorial Hospital in Woodstock, N.B.

Julia Helena Barbara Ryfa has been appointed superintendent of nurses of the Brandon Mental Hospital where she graduated five years ago. Miss Ryfa recently completed a course in supervision in psychiatric nursing at the McGill School for Graduate Nurses. Outside the professional sphere, Miss Ryfa's chief joy is ballet. She plans to start a collection of recordings of ballet and classical music. Bowling and leathercraft supply her with interesting hobbies.

JULIA RYFA

Dorothy Hibbert is now assistant superintendent of nurses of the Winnipeg General Hospital. Born and educated in Boissevain, Man., Miss Hibbert graduated from W.G.H. in 1937. She received her certificate in teaching and supervision from the University of Manitoba School of Nursing in 1944. For nine years Miss Hibbert served as head nurse on several surgical wards at W.G.H. and for two years has been clinical supervisor in surgical nursing. She was a member of the provincial R.N. examination committee for four years and is currently a member of the Board of Directors of the M.A.R.N. She turns to handicrafts for her leisure-time activities, including petit point, glove making, etc.

Anne Catherine Munro, who graduated from the Winnipeg General Hospital in 1919, has had a rich and full life in her work in India under the Canadian Baptist Foreign Mission Board. In addition to her medical

Courtesy Winnipeg Tribune

ANNE C. MUNRO

and evangelistic service, Miss Munro has translated the Scriptures into the language of the Saora Hills tribe. She was the recipient of the Kaiser I Hind Medal in 1946 for distinguished humanitarian service with special reference to Saora language research. Miss Munro has the unique distinction of being a member of the Legislative Assembly of Orissa. She was nominated to this important office by the governor to represent the scheduled castes and tribes of Parlakimedi Agency of Ganjam.

Esther Mary Beith, who retired in August after fulfilling 25 years as executive director of the Child Health Association of Montreal, is one of those rare persons who was able to combine the scientific approach required in modern health practices with spontaneous sympathy and understanding. Thus she has built up a strong and active organization, providing a much needed service for the children of Montreal. At the same time her sound judgment, her vision of future possibilities in health services, and her ability to rapidly and effectively assess current problems has resulted in her advice being sought by welfare authorities far beyond the limits of her own agency in Montreal.

Miss Beith graduated from the Hospital for Sick Children, Toronto, in 1914. For nine years she was on the staff of the Toronto Department of Public Health, during which time she assisted as a part-time lecturer in the newly established School of Nursing at the University of Toronto. She was superintendent for a year at the Dalhousie University Clinic in Halifax before beginning her work in Montreal. The McGill School for Graduate Nurses benefitted by her services as a part-time lecturer for nine years. Professional nursing, too, has been the richer for the work and guidance which Miss Beith offered through the various associations. Her greatest reward was always to see how well her protégées progressed.

In preparation for her retirement, Miss Beith had built a cottage at Herring Cove on the Nova Scotian coast near Halifax. Here, her living-room windows look out over the sea that she loves. Long years of happiness to you, Esther Beith!

ESTHER BEITH

Beatrice E. Williams, who for the past 26 years has been on the staff of Ste. Anne de Bellevue D.V.A. Hospital, has retired. Miss Williams is a veteran of World War I. She enlisted in 1916 and served overseas in England and France until 1919. The staff honored Miss Williams on her retirement with a tea at which they presented her with a beautiful table lamp.

Hope springs eternal in the human breast but a wishbone never took the place of a backbone!

Trends in Nursing

Average reading time — 4 min. 48 sec.

THE PAST SEVERAL ISSUES of the *Journal* have pieced out the picture of the 25th biennial convention with fairly full coverage of the papers presented, the work conference reports, and the general picture of events. There remain still to be recorded here the resolutions that were unanimously adopted and, as a final wind-up, the lists of the members appointed to act on the various committees. It is hoped that all of the acceptances to act will have been received in time to permit us to publish these lists on this page next month. The resolutions and recommendations were presented to the last session of the convention.

Work Conferences

Following the presentation of the summaries of the work conferences, the president, Miss Cryderman, suggested that possibly the time has come when work conferences should be considered on the regional and provincial rather than the national level. This proposal was endorsed by Miss Marion Myers in her brief words of thanks to the various consultants. We shall hope to see a much wider development of this educational pattern than has heretofore been practised. National Office is always delighted to receive requests for assistance in the organization of such programs. The provincial association headquarters staffs are also well equipped with information on how to organize work conferences locally. What can you plan in your own community?

Resolutions

National emergency: In reporting on the registrars' informal discussion of international affairs, Miss Lillian Pettigrew explained that there was no thought of casting a shadow of gloom over the convention by the introduction of a resolution pointing to any possible national emergency, but rather it was intended that some consolidation of thinking would precipitate a readiness to assume the responsibilities of the Canadian Nurses' Association if such a situation should arise. The following resolution was unanimously adopted by a standing vote accompanied by the applause of the members:

WHEREAS, Recent developments in international relationships suggest the possibility of a national emergency arising; and

WHEREAS, In such an event nursing services would be of major importance; and

WHEREAS, The Canadian Nurses' Association, representing more than 30,000 registered nurses, would be able to assist in any needed mobilization of nursing services; therefore be it

Resolved, That, in the event of a national emergency, the President be authorized to call immediately a special meeting of the full Executive Committee of the Canadian Nurses' Association to plan and initiate appropriate action.

The report of the Resolutions Committee was read by Miss Rae Chittick. The first resolution dealt with the problem of *financial support for schools of nursing:*

WHEREAS, The cost of operating schools of nursing is not known at the present time; and

WHEREAS, The first step to take before making any approaches for financial assistance is to know the cost of educating student nurses; therefore be it

Resolved, That Provincial Associations be advised to approach their Health Departments to ascertain the formula to be followed in satisfactorily separating school of nursing and hospital costs and to urge that Federal Grant money be allocated for support of schools of nursing and, moreover,

That hospital schools be encouraged to take immediate steps to separate such costs and, further, that hospital schools

submit definite projects for assistance through the Federal Health Grants to their provincial Health Departments. When the time seems opportune the Canadian Nurses' Association should again request the Federal Government to consider the possibility of making direct grants to nursing education. In making such an appeal the Canadian Nurses' Association should endeavor to gain the support of the Canadian Hospital Council and the Canadian Medical Association.

It was pointed out that, in approving this resolution, the general membership had agreed that such action should not nullify former resolutions with respect to approaches to governments for financial support for nursing education.

* * *

WHEREAS, The General Interest Sessions have proven both interesting and profitable in keeping nurses in touch with newer nursing procedures; therefore be it

Resolved, That such General Interest Sessions, particularly the Neurological Nursing Demonstration, be incorporated into the program of the next biennial meeting.

* * *

Two resolutions had grown out of the general session of the Public Health Nursing Committee. These were presented to the convention for endorsation by the membership of the Canadian Nurses' Association:

WHEREAS, The Public Health Nursing Committee of the Canadian Nurses' Association endorses the report of the Study Committee on Public Health Practice in Canada; and

WHEREAS, It is felt that this important study should receive the serious consideration of all nurses engaged in both service and education; therefore be it

Resolved, That the Public Health Nursing Committee of the Canadian Nurses' Association join the Public Health Nursing Section of the Canadian Public Health Association in an endeavor to stimulate interest in the study of the report on the local, provincial, and national levels with a view to implementation of the findings in as far as is possible.

* * *

WHEREAS, The Public Health Nursing Committee of the Canadian Nurses' Association supports the recommendation of the report of the Study Committee on Public Health Practice in Canada "that a study be made of methods of preparing nurses so that they may be more fully qualified to contribute to the community health services"; therefore be it

Resolved, That this matter be referred to the Educational Policy Committee of the Canadian Nurses' Association and to the Council of the University Schools and Departments of Nursing for action.

Orientation et Tendances en Nursing

Les derniers numéros du *Journal* contenaient les activités du 25e congrès biennal, les travaux présentés, les rapports des foyers d'étude, et un aperçu général des événements.

Il reste à vous faire part des résolutions adoptées et, en finale, à vous donner la liste des membres appelés à siéger sur les divers comités. Nous espérons que les membres de ces comités donneront leur réponse d'ici au mois prochain et que nous serons alors en mesure de publier cette liste. Dans ces colonnes, nous vous présentons les résolutions et les recommandations faites à ce congrès.

FOYERS D'ETUDE

Après la présentation des rapports des foyers d'étude, la présidente, Mlle Cryderman, suggéra que le temps était peut être venu de considérer l'organisation de foyers d'étude comme une activité provinciale plutôt que nationale. Mlle Myers approuva cette suggestion et remercia les consultants des foyers d'étude. Il est à espérer que cette méthode d'étude se diffusionnera plus que par le passé. Le secrétariat de l'Association des Infirmières du Canada est toujours heureux de répondre aux demandes qui lui sont faites pour l'or-

ganisation d'un tel programme. Les associations provinciales sont aussi en mesure d'aider. Que pouvez-vous organiser dans ce sens dans votre district?

* * *

En présentant le rapport d'une discussion entre les registraires sur les relations internationales, Mlle L. Pettigrew expliqua qu'elle ne voulait pas jeter une ombre au tableau en proposant une résolution concernant l'état d'urgence du pays mais plutôt présenter une idée pratique permettant à l'A.I.C. d'assumer toutes ses responsabilités dans une situation d'urgence.

La résolution suivante fut adoptée à l'unanimité, aux applaudissements de l'assemblée:

"CONSIDÉRANT, Que le développement des relations internationales peuvent amener un état d'urgence au pays; et

CONSIDÉRANT, Que dans un état d'urgence les services des infirmières deviendront d'une importance primordiale; et

CONSIDÉRANT, Que l'A.I.C., représentant plus de 30,000 infirmières enregistrées, serait en mesure d'aider en cas de mobilisation des services des infirmières; il est donc

Résolu, Qu'en cas d'état d'urgence du pays, la présidente soit autorisée à convoquer immédiatement une réunion spéciale du Conseil de l'A.I.C. afin de déterminer les plans à adopter et la conduite à tenir."

Le rapport du Comité des Résolutions fut présenté par Mlle R. Chittick. La première résolution concerne *l'aide financière aux écoles d'infirmières:*

"CONSIDÉRANT, Que le coût de revient d'une école d'infirmières n'est pas actuellement connu; et

CONSIDÉRANT, Que la première chose à faire, avant de demander une aide pécuniaire, est de connaître le coût de l'éducation de l'étudiante infirmière; il est donc

Résolu, Que chaque association provinciale se mette en rapport avec leur Ministère de la Santé respectif afin de connaître la meilleure méthode à suivre pour établir une comptabilité, séparant le coût de l'école et celui de l'hôpital, et d'insister auprès d'eux pour que des octrois, provenant des Octrois Fédéraux, soient accordés aux écoles d'infirmières; en plus, que l'on encourage les hôpitaux à prendre les mesures nécessaires pour établir le prix de revient de l'école d'infirmière et de l'hôpital et que chaque école d'infirmière soumette à leur Ministère de la Santé les projets définis pour lesquels ils ont besoin d'assistance."

En temps opportun, l'A.I.C. fera de nouveau des demandes auprès du Gouvernement Fédéral afin d'obtenir que des octrois soient versés directement aux écoles d'infirmières; dans ce cas l'A.I.C. demandra de nouveau appui du Conseil des Hôpitaux canadiens et de l'Association canadienne des Médecins.

Il est à remarquer, qu'en appuyant cette résolution, que la résolution semblable, préalablement adoptée par les membres, n'est pas annulée, à savoir:

"Que des démarches soient faites auprès du gouvernement pour obtenir une aide financière pour l'éducation des infirmières."

* * *

"CONSIDÉRANT, Que les séances d'intérêt général ont été à la fois d'un grand intérêt et d'un grand bénéfice pour les infirmières, leur permettant ainsi de se tenir au courant des nouvelles techniques concernant le soin des malades; il est donc

Résolu, Que ces séances d'intérêt général, particulièrement les démonstrations données par l'Institut Neurologique, soient au programme du prochain congrès biennal."

* * *

A la suite de la réunion du Comité de l'Hygiène Publique deux résolutions furent formulées et présentées aux membres du congrès afin d'obtenir leur approbation:

"CONSIDÉRANT, Que le Comité de l'Hygiène Publique de l'A.I.C. approuve le rapport du Comité d'Étude sur l'hygiène publique au Canada; et

CONSIDÉRANT, Qu'il est très important que cette étude soit portée à l'attention des infirmières travaillant à l'hygiène publique ou à l'éducation des infirmières; il est donc

Résolu, Que le Comité d'Hygiène Publique de l'A.I.C. se joigne à la Canadian Public Health Association (section du nursing) afin de stimuler, dans un effort commun, l'étude du rapport précité tant dans les milieux provinciaux que nationaux afin de donner suite aux considérations émises dans ce rapport."

* * *

"CONSIDÉRANT, Que le Comité d'Hygiène Publique de l'A.I.C. appuie la recommandation faite dans ce rapport 'd'étudier les méthodes employées dans la formation de l'infirmière afin qu'elle soit mieux préparée à remplir le rôle important qu'elle est appelée à rendre dans la société'; il est donc

Résolu, De soumettre cette question au Comité d'Education de l'A.I.C. et Conseil des Ecoles Universitaires et Départements du Nursing."

Student Nurses

Corpus Luteal Hemorrhage Surgery and Nursing Care

CAROLYN F. HARVIE

Average reading time — 14 min. 24 sec.

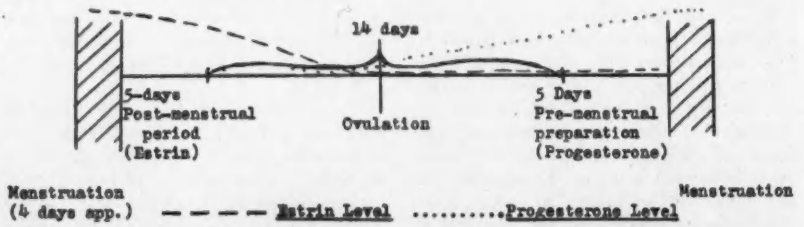
INTRODUCTION

IF QUESTIONED, most nurses' reasons for the selection of a particular patient for a case study would be, first, her interest in this patient and, secondly, her interest in the patient's disease. If the disease occurs only rarely, the case study is done because the nurse feels an urge to know why this disease is so rare, what can be done for it, and so on. If the disease is very common the student may write the report because she wishes to use the knowledge obtained in nursing the disease in future years.

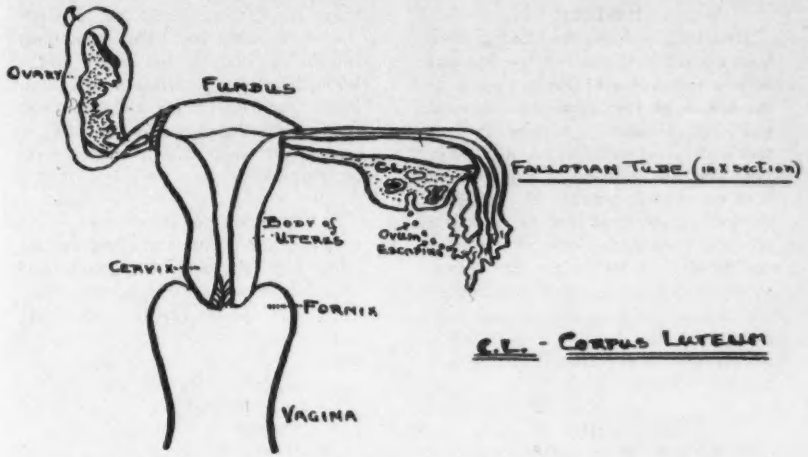
Mrs. Daw's disease is particularly rare. Here was a woman who managed to look after her home, husband, and two infant children with no outside help and, although tired much of the time, kept this home running smoothly and herself in good health. Then, suddenly, she is admitted to hospital with a diagnosis of "acute abdomen —possible ectopic" and upon immediate laparotomy is discovered to have a "corpus luteal hemorrhage." What caused this to happen so suddenly and why to a woman normally appearing in the best of health?

THE MENSTRUAL CYCLE

To explain her diagnosis, I will discuss the menstrual cycle. Ovulation begins in adolescence, continues through maturity, and ceases at the menopause. Under normal conditions in the female, it proceeds smoothly and does not cause any significant symptoms. In the first two weeks of the menstrual cycle, the uterine muscle motility is greatest with the hormone, estrin, in control. Estrin is produced by the follicular stimulating hormone contained in the secretions of the anterior lobe of the pituitary gland. With the rupture of the mature Graafian follicle and the production of the corpus luteum, the uterine muscle motility is decreased under the direct influence of progesterone. Progesterone is produced by the action of the luteal stimulating hormone on the corpus luteum. It is hardly possible that the Graafian follicle can rupture without the loss of a little blood from the point of rupture or from the bed of the ovum. As a rule, it is microscopic! However, the cavity may fail to heal and severe intraabdominal bleeding occur, causing symptoms much like those of a ruptured tubal pregnancy (ectopic). The menstrual cycle proceeds as per the accompanying illustration.



Miss Harvie is a very recent graduate of the Vancouver General Hospital who prepared this study during her senior year.



"Painful ovulation," under which corpus luteal hemorrhage is classified, is not common. Pain may occur between menstrual periods, regular in occurrence, and often preceding the following menstrual period by a fixed number of days. The pain is usually located in the suprapubic region, in one or both iliac fossae. Occasionally it is felt only on one side in the ovarian region. Most commonly it is located diffusely through the whole pelvis and is said to resemble dysmenorrhea. This pain is notably absent during pregnancy and lactation. There are no definite predisposing factors.

There are three clinical types of menstrual pains: First, the chronic mild type which is a classic variety referred to as "periodic intermenstrual pain." In the second type there is more severe pain which lasts longer and definitely undermines health of both the body and mind. The third type is that associated with severe intraabdominal bleeding from the ruptured ovary. Here shock dominates the picture.

Symptoms associated with these types are: dysmenorrhea, vaginal bleeding, and intraabdominal hemorrhage where symptoms also simulate a ruptured ectopic—severe abdominal pain in left lower quadrant, referred pain in right shoulder, and a pallid complexion. Physical and palpatory findings in the third type include:

1. Leukocytosis—W.B.C. may go up to 30,000 per cu. mm.
2. The temperature rises but is usually not too high.
3. Tenderness through whole pelvis, cul-de-sac and both fornices and blood in the cul-de-sac. (This may be verified by a posterior colpotomy.)

Diagnosis is difficult with this severe intraabdominal bleeding. During the first attack, there is no history of preceding intermenstrual pain. Also, one rarely gets the history of recurring periodic pain. A preoperative diagnosis of a ruptured tubal pregnancy is usually made unless the patient is a virgin, has had the same disorder before, or has had a salpingectomy previously. However, it is difficult to eliminate a ruptured ovarian cyst, abdominal hemorrhage from other sources, and other acute pelvic conditions. Diagnosis of corpus luteal hemorrhage can only be made after a laparotomy is done.

Treatment of this third type of painful ovulation is a laparotomy immediately and suturing of the corpus luteum plus supportive therapy. Shock is combatted with blood and intravenous therapy, complete rest, warmth, and circulatory stimulation. The situation rarely recurs.

History

Mrs. Daw is a healthy-looking, well-built woman of 42 years of age. She was born in Belgium and came to Canada at the age of 10. Her mother died several years ago of diabetic gangrene—her father is alive and well. She was married in 1942 and her husband is a motorman with an electric railway. She has two children—a girl three years of age and a boy one year. Both births were normal and the children are healthy. She prefers to do her own housework although they are financially able to afford a part-time maid. Mrs. Daw does not seem to worry unduly and always appears happy and content with life.

Medical History

In the late summer, Mrs. Daw was tired all the time and did not feel in the best of health. She had no pains or excessive bleeding during her periods but had no energy to do the housework or play with the children. Her menses have always been normal with the occasional pain, but nothing out of the ordinary. Her last menstrual period before entrance to hospital occurred between August 1-5 and was normal. On August 1 she had a severe pain in her abdomen—so severe that she had to lie down. This pain lasted about two hours then passed off. A week later, she again had an episode of pain—sharp, lower abdominal pain, with nausea and vomiting. She fainted going to the bathroom. The pain continued until the afternoon when she called her doctor, who did a pelvic examination and gave her some penicillin. The pain lessened for a while but started up again that evening. Then she began to have pains in the shoulder—the left one first, then both. It also hurt her to breathe. The lower abdominal pain did not localize to either side. Mrs. Daw fainted twice that evening and her doctor advised admission to the hospital.

Physical Findings

Mrs. Daw looked normal on admission. She was not pale and had only minimal abdominal discomfort. There was no flow or vaginal discharge.

On palpation, her abdomen was tender all over, more pronounced in the lower quadrant, but not more on one side than the other, indicating bilateral trauma of some sort. The laparotomy revealed a cyst in one ovary and a hemorrhage from a corpus luteum in the other. There was some abdominal distention showing irritation of the intestines by some foreign matter — the escaping blood.

Laboratory Findings

Emergency white and differential, cross and grouping on blood, and urinalysis were done on admission. There were no post-operative laboratory reports.

Urine: pH 6—acid		Normal
All cells—negative		"
S.G.—N.S.Q.		
Protein—0		"
Sugar—+1		
Acetone—+2		Showing dehydration or faulty fat metabolism probably caused by overfatigue.
Blood: W.B.C.—14,200/cu. mm. 5,000—9,000 cu. mm. increased		
Polys—72	33—78%	
Lymphs—14	18—65%	Low
Monos—3	0— 9%	
Eosins—1	0— 6	
Staffs—10	0— 5	Increased
Blood group—O—Rh+		

Pathological report: Specimen sent from operating room showed part of an ovary in which there is a large corpus luteum showing evidence of hemorrhage.

Operating Room Report

Under spinal anesthesia, the patient was put in lithotomy position and a large needle was passed into the pouch of Douglas. Both free and clotted blood were found, indicating internal abdominal hemorrhage. The patient was then prepared for a pelvic laparotomy. A left paramedian incision was made. On opening the abdomen, a large amount of free and clotted blood was found. Both tubes were normal but the uterus was slightly enlarged. The left ovary showed a cyst the size of a hen's egg, which ruptured on manipulation. The right ovary showed a corpus luteum with a lot of adherent blood clots. This was probably the origin of the abdominal hemorrhage. The corpus luteum was

resected and the base oversewn. The appendix was normal but was removed in the usual manner. The abdomen was closed in layers.

Preoperative Care

With an emergency operation such as Mrs. Daw had, there are, of necessity, many preoperative nursing procedures dispensed with, such as an enema. The patient was locally prepared, both abdominally and vaginally, and preoperatively examined by the interne. Mental reassurance is of the utmost importance in cases such as these. A nurse must never show the patient that her case is serious by actions or words. However, since Mrs. Daw is normally an optimistic woman there was little need for reassurance.

She was sent to the operating room with a medication of morphine gr. 1/6 and atropine gr. 1/150 (after voiding). An hour later she returned to the ward in good condition—conscious, B.P. 120/50, P. 124 and bounding.

Post-Operative Nursing Care

The patient was placed on her side with one knee drawn up slightly and pillows placed behind her back to make her more comfortable. This position allows a free passage of air at all times, and if the patient vomits or has an increase in salivary secretions she will be less apt to aspirate them and thus cause pneumonia or asphyxia.

Upon return to consciousness, Mrs. Daw was placed in semi-Fowler's position, allowing for better drainage and also causing less strain on abdominal muscles by flexing of legs. As she progressed, she was allowed in high Fowler's position and on the second day was up in a chair. Moving about in bed was stressed from the time of her return to consciousness to prevent any post-operative complications. Deep breathing exercises were also instituted.

Sedation: Morphine gr. 1/3 was ordered q. 3 h. and p.r.n. for relief of pain from operative discomfort. This order only lasts until 48 hours after the operation when such medication is usually not considered necessary. Continued use of morphine is undesirable because of its habit-forming character. A tolerance for it is rapidly acquired. Mrs. Daw required it only twice. Good nursing care minimizes the need for morphine—i.e., frequent changes of position, use of pillows, etc., to promote the comfort of the patient. Seconal gr. 1½ was also given at h.s. to promote a good sleep.

Observations: Mrs. Daw's temperature after the operation remained normal and her pulse, respirations, and blood pressure remained constant at all times. There was no excessive drainage from the incision. Good sterile technique was practised, preventing any chance of infection in the wound. On the seventh day, the clips were removed and the incision appeared clean and well healed.

After the first day, there was no vaginal discharge but the area was kept clean by frequent perineal care, preventing any chance of infection through the vagina.

Diet: Mrs. Daw was on a fluid diet for the first 24 hours because she was occasionally nauseated and vomited several times. An intravenous of 2,000 cc. of 5% glucose in saline and a transfusion of 500 cc. of whole blood prevented any dehydration and helped to replenish some of the blood lost as a result of hemorrhage. She improved so rapidly that from the second day until her discharge she was on a full diet, showing that the more rapid the return to a normal diet the more rapid the convalescence. Forcing fluids to 3,000 cc. per day after an operation is very necessary, as it eliminates toxins and prevents dehydration.

Catheterization: If necessary it is done in 8 hours and every 8 hours following until patient voids on her own. Mrs. Daw was catheterized once then voided normally. Catheterization is another method of assuring the comfort of the patient and lessens chances of operative discomfort.

Distention: Post-operative distention can usually be prevented by keeping the patient moving. It can be relieved by insertion of a rectal tube, turpentine stupes, and so on. Distention was Mrs. Daw's only post-operative discomfort. A rectal tube seemed to do much to relieve her.

On the third day, she had a Mayo enema with good results. Being out of bed so soon after her operation and taking walks down the hall helped to make her

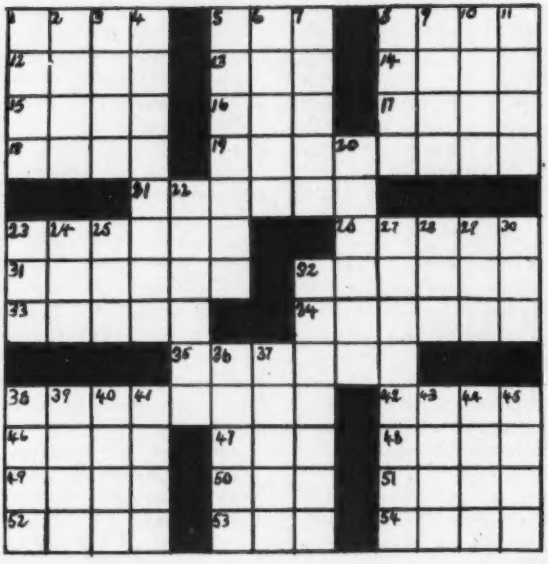
bowels move regularly. No further enemas were necessary.

Post-operative nursing care is extremely important. Without proper care the patient may never get back to her normal self. Alcohol rubs, pillows placed in comfortable positions, and quietness all help to make the patient's stay in hospital more pleasant. Having a cooperative patient is an added incentive.

Health Instruction

Mrs. Daw was instructed not do do any heavy chores for several weeks to allow her incision to heal well and to prevent any possibility of herniation. She was also instructed to call her doctor immediately if she had the same type of pain again around the ovulation period. Any irregularities in her menses were also to be reported.

CROSSWORD PUZZLE



ACROSS

1. Suffer continuous pain.
5. A sebaceous cyst.
8. Outer covering of beans.
12. Plumbum.
13. After the manner of (Fr.).
14. French word of caution.
15. Bone in forearm.
16. Angular distance on a meridian (abbr.).
17. Jump.
18. Doctor who lost his eye.
19. Plank frame on flat-bottomed boat to lessen leeway.
21. Jumbled vowels plus S.
23. Take the orat out of a place for experiments.
26. Less common.
31. Light up.
32. Act of yawning.
33. Equilibrium.
34. A birth-mark.
35. Classify.
38. Sun-room.
42. Pigmented perforated membrane.
46. Goes quickly.
47. Greek prefix meaning "through."
48. Dreadful.
49. Alack and —.
50. Long narrow tube (abbr.).

51. A mental impression.
52. Start being obscure.
53. That part of the mind which possesses consciousness.
54. Bird's home.

DOWN

1. Astringent.
2. Suffix indicating a tumor.
3. Terminal part of arm.
4. Of eating; greedy.
5. Divergent strabismus.
6. Comb. form for oil (Greek).
7. Buttocks.
8. Nimbus.
9. The iris, ciliary body, and chorioid together.
10. Prevaricator.
11. Lawyer, surgeon, priest, dentist (abbr.).
20. Treasurer.
22. An extremity and an organ (two words).
23. Edge of wound.
24. Add E to get a purgative drug.
25. Half joyous.
27. Same as diacetin.
28. Abbreviation for a clergyman.
29. This cate will help you learn.
30. This ace is a rose-window.
32. The kind of phobia with a morbid dread of hearing a certain name.
36. Walk obliquely.
37. Making entreaty.
38. Humbug.
39. Fawning.
40. Grassy lands.
41. A shortened helper.
43. Dominate.
44. Angers.
45. Stool.

(Solution on page 920)

The Importance of Breakfast

The nurse who gets up at the last minute and rushes on duty minus breakfast is piling up trouble that will make itself felt sooner or later. There has already been a fasting period of eight hours or more since the last meal on the previous day; another 4-hour period without breaking the fast is not conducive to a good morning's work. Get up a few minutes earlier for a hot beverage and cereal or toast, at least; better still, make it fruit juice, beverage, bacon and/or egg with toast.

—Dept. of National Health & Welfare

Accidents are far more important as a cause of death among females than is generally realized. Each year a greater number of girls and women are killed by accidental injuries than die from any other cause except the cardiovascular-renal diseases and cancer. Accidents are the greatest single menace to life in childhood and adolescence. In order of frequency the causes for all ages are falls, motor vehicle accidents, burns, conflagration, drowning.

—M.L.I.C. Statistical Bulletin

Book Reviews

Medical Nursing, by Edgar Hull, M.D. and Cecilia M. Perrodin, R.N., B.Ed., M.S. 826 pages. Published by F. A. Davis Co., Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 4th Ed. 1949. Illustrated. Price $4.75.

Reviewed by Clara Aitkenhead, Instructor of Nurses, Alexandra Hospital, Montreal.

This book has achieved one of the chief aims of the authors, in that particular emphasis is placed on fundamental principles. The first unit is very inclusive and comprehensive in general basic facts, a sound knowledge of which is essential to good nursing care. In the remaining units the introductions deal briefly with anatomy,

physiology, and cause of disease, thus the effect of illness should be better understood. The clearly outlined clinical picture of the patient as presented should assist the student nurse in carrying out nursing care and anticipating the special needs demanded by the illness.

Special features include the contemporaneous explanation of new terms; full bibliography with particular reference to current nursing magazines; nursing factors in observation of symptoms; inclusion and explanation of pertinent laboratory tests which, correlated with medical nursing, enable the student to more intelligently understand their value and importance in diagnosis; detailed factors of importance in administering drugs; suggested reviews of basic nursing procedures; and mental preparation of patients, especially for new procedures.

I feel this book is an excellent contribution to the school of nursing library and should stimulate the young student nurse by its detailed yet concisely outlined care of the medical patient.

Essentials of Gynecology, by Leo Brady, M.D., Ethna L. Kurtz, R.N., and Eileen McLaughlin, B.S., R.N. 256 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1949. Illustrated. Price $3.00.

Reviewed by Verna Williams, Clinical Instructor in Surgical Nursing, St. Boniface Hospital, Man.

This book, in which the authors present the material in a brief and simplified form, will serve as an excellent reference in gynecology.

In the first section the authors present a comprehensive review of the anatomy and physiology of the organs of reproduction. Following this are two very excellent chapters stressing the importance of a complete and accurate history and examination, also one chapter discussing symptoms specific to a gynecological patient.

The diseases and disorders of the reproductive organs are defined and discussed. This material is well organized and clearly presented. There are several chapters relating to gynecological surgery—both operating room and post-operative care. In most instances emphasis is placed on general principles of care rather than specific techniques. One chapter discusses female urology very thoroughly, which topic is not always found in gynecology texts. The last chapter presents radiation therapy very briefly.

There are excellent illustrations throughout which make it possible to visualize the material presented. A bibliography at the end of each unit would have made the book more valuable by suggesting to nurses additional sources of information.

Graduate nurses who are working in gynecology would find this a valuable reference book and it would supplement lectures given in gynecology to student nurses.

Ward Administration, by Margaret Randall, R.N., M.A. 326 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Price $4.40.

Reviewed by Carol M. Adams, Associate Director of Nursing Education, Kitchener-Waterloo Hospital, Ont.

Those who are faced with the problem of administering a ward will find Miss Randall's book most helpful and stimulating. Although it was written primarily for students in ward administration courses and for head nurses, it would be valuable to persons in other departments of the hospital who are interested in the welfare of the patient. Miss Randall states in her preface: "The emphasis in this book is placed on democratic administration with the goal of developing each member of the hospital health team so that everyone is stimulated to give patients the best possible care."

It is a comprehensive, well organized, and interesting book, containing a wealth of practical and well-documented information on the various aspects of ward administration. A helpful reference list is included at the end of each chapter.

This book is considered a "companion" book to "Clinical Instruction" by Amy Frances Brown. It is divided into six units as follows: Unit I, The Hospital Patient; Unit II, The Environment of the Patient; Unit III, the Personnel of the Patient's Environment; Unit IV, Principles of Administration; Unit V, The Head Nurse's Place in the Hospital Organization and in a Community Health Program; Unit VI, Qualifications and Preparation for the Head Nurse Position.

The author's emphasis is on the administration of a service which is practical, carefully analyzed, and aimed at the individual needs of the patient. Included are discussions on many of the all-important

questions of the day, such as team method of assignment, job satisfaction, role of subsidiary workers, methods of assigning patients, and duties and floor coverage.

The author discusses briefly but very frankly some of the disputable questions which head nurses face—for example, case assignment versus functional assignment and problems in medical-nursing relationships.

Methods of conducting studies to evaluate present nursing practice are explained and sample forms included. The scientific approach toward evaluating the nursing needs of patients is emphasized throughout. Some nursing care plans are included for illustration

Throughout the book the relationships of other departments in sharing the responsibility for administrative service to the patient is clearly shown, together with the essential and invaluable assistance of the head nurse in planning the construction and remodelling of hospital facilities. A short chapter is devoted to the role of the hospital in maintaining community health.

Signs and Symptoms—Their Clinical Interpretation. Edited by Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P. 439 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. Illustrated. Price $14.50.

Reviewed by Mrs. Catherine L. Townsend, formerly Instructor of Nurses, Montreal General Hospital.

With names such as Bar, Freyburgh, and Wolff among the contributors there is no question of the excellence of this work which is written for doctors. However, the well prepared clinical teacher in nursing schools may find this a valuable reference. In developing "trained observation" among students this book can be used, first as a guide as to what to look for and, second, as a form of catalogue where one can classify what has been observed.

Twenty-one doctors, specialists in their fields, contributed to this volume. The book is divided into 27 sections each dealing very thoroughly with the subject involved and these subjects vary from pain to pruritis, from joints to jaundice.

This book may be dipped into as a reference but two sections should be read before delving—the first is the Introduction and the second is the chapter on pain.

The Introduction deals with the process of analyzing and interpreting symptoms—the present illness, the association of symptoms, and the importance of a complete history. This paves the way for intelligent use of the other 26 sections.

The chapter on pain is also a basic one. No matter how distressing other symptoms may be, it is *pain* and the relief of pain that is the prime consideration of the patient.

Each section has a concise summary at the end of the chapter. It is difficult to choose illustrative material from such a wealth of information but there are certain divisions which might serve the nurse well.

The chapter on fever seems particularly good: beginning with heat production and heat elimination it covers the subject from all angles. Then with the stress today on water balance and with "transfusion" and "intravenous" household words, the chapters on dehydration and edema are of great interest. Headache being no respecter of persons I believe Chapter Three to be a very useful one.

When using this text it is necessary to stick very closely to the subject in hand or, as when consulting the encyclopedia, fascinating bits of information will entice you far afield.

Communicable Disease Nursing, by Theresa I. Lynch, R.N., Ed.D. 776 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Illustrated. Price $5.50.

Reviewed by Aileen Flett, Director of Nurse Education, Mountain Sanatorium, Hamilton.

The second edition of this book presents the care of the patient with communicable disease as it may be practised in the modern hospital or in the home.

The content has been carefully reviewed and brought up to date emphasizing the modern concept of treatment, methods of control, nursing care, patient education, and rehabilitation. The book is divided into five parts: Orientation to communicable disease nursing; medical aspects and nursing care of communicable diseases; tuberculosis; venereal disease; communicable diseases and the community; while the less common communicable diseases are dealt with in an appendix. The pictures and graphs illustrate the subject matter well.

The salient points in each chapter are summarized under Essential Points to Remember and Community Protection with references and suggested readings.

In Orientation, page 36, this statement occurs: "B.C.G. vaccination is advised in some institutions for nurses who react positively to the tuberculin test." This is an obvious typographical error as B.C.G. is of value for nurses who are negative reactors to tuberculin.

The text is comprehensive and of more than usual interest. It should prove useful as a guide to instructors, a reference book for nurses, and a text for students.

A Handbook for Industrial Nurses, by Marion M. West, S.R.N., S.C.M., with contributions by Valerie Bowerman, S.R.N., and H. F. Chard, M.B. 264 pages. Published by Edward Arnold & Co., London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1949. Price 75 cts.

Reviewed by Theresa Greville, Industrial Nurse, Winnipeg, Man.

The author has given a history of one hundred years' growth of welfare work, labor legislation, and industrial nursing in England —from 1842 to the post-war legislation of 1948 under the present Labor Government.

The duties and responsibilities of the industrial nurse are outlined with a wealth of detail. Nothing is forgotten—from the furnishing of the first aid department, specific treatments for occupational and non-occupational illnesses and accidents, to the hours of duty and suggested salary; how to present reports, with samples of form letters; a special chapter on eye injuries written by Dr. Chard—to the dangers of the nurse working alone and assuming responsibilities beyond her sphere. Professional ethics is defined as "the practical application of the Nightingale Pledge."

The book could well be used as a manual for a study group. Attention should be given to the fact that some expressions in the book are not in use in industrial literature on this continent. Nurses guided by the contents of the book could study their own federal and provincial legislation for the protection of workers.

There is no gaiety or humor in the book. It bristles with starched efficiency but, nevertheless, it is not only a book industrial nurses should read but they should keep it at hand for constant reference. There is an index that the busy nurse working alone will appreciate.

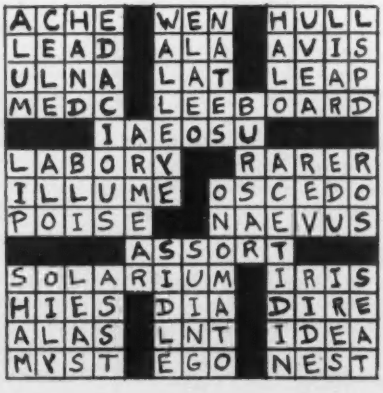
Leading Causes of Death

Diseases of the heart are now responsible for one-third of all the deaths in the United States, three times the proportion in 1910. The accompanying figures show the change that has taken place during the past 37 years.

—M.L.I.C. Statistical Bulletin, June 1950

Rank of Five Leading Causes of Death in Specified Age Groups, White Persons, by Sex. United States, 1947 and 1910

Males				Females			
1947		1910		1947		1910	
Cause of Death	% of all Causes	*Cause of Death*	% of all Causes	*Cause of Death*	% of all Causes	*Cause of Death*	% of all Causes
All Ages							
Diseases of heart	35	Tuberculosis	11	Diseases of heart	31	Diseases of heart	11
Malignant neoplasms	13	Pneumonia and influenza	11	Malignant neoplasms	17	Pneumonia and influenza	11
Accidents	8	Diseases of heart	10	Cerebral hemorrhage	9	Tuberculosis	10
Cerebral hemorrhage	7	Accidents	8	Nephritis	6	Diarrhea and enteritis	8
Nephritis	5	Diarrhea and enteritis	8	Accidents	5	Malignant neoplasms	7



Story of Marmalade

In the 18th century a Scottish grocer, James Keiller of Dundee, heard that a storm-bound Spanish ship had taken refuge in the port. Its cargo of sugar and oranges was going cheap.

Never one to miss a bargain, James went out to buy. He took the oranges and sugar home to his wife, who had a family reputation for her quince jelly.

She concocted a new preserve which she tried on her family and friends. They liked it. James then tried the marmalade on his

customers. They liked it so well that James gave up being a grocer and became a marmalade manufacturer.

In 1797 he set up a company which, to this day, continues to manufacture marmalade, much of it finding its way to breakfast tables in Canada.

—*The Vancouver Daily Province*

M.L.I.C. Nursing Service

Brigitte Beaudet (Notre Dame Hospital, Montreal) and *Bernadette Tessier* (Ste. Justine Hospital, Montreal) have been granted scholarships by the Metropolitan Life Insurance Company to attend the School of Public Health Nursing, University of Montreal. *Simonne Rouillard* has resigned from the company's service.

Alberta

The following is news regarding the staff of the Division of Public Health Nursing, Alberta Department of Public Health:

Laura M. Attrux, of Smith, has been appointed to teach the advanced course in practical obstetrics at the University of Alberta and is residing in Edmonton. *Marie Therese Lefebvre* and *Miss Mitchell* of the nursing staff are among those taking the course.

Margaret McKim and *Laura Graham* have returned to their duties in the Schools of Agriculture at Olds and Vermilion after relieving in Worsley and Tangent during the summer. *Edna Carveth* is on leave of absence to take the public health nursing course at the University of Toronto. *Eleanor Jamieson*, formerly at Colinton, is relieving *Rae Chittick* at the Calgary School of Education.

Appointments: *Elodie I. Brière* (St. Boniface Hosp., Man.) to Vauxhall; *Sarah Furgeson* (Calgary Gen. Hosp.; B.Sc., University of Alta.) to Bow Island; *Cathie Somerville* (after taking University of Toronto

public health course) to Plamondon.

Transfers: *K. Ambrose* from Fort Assiniboine to Warner; *Dorothea Engelcke* from MacKay to Fort Assiniboine; *Tillie Holowaychuk* from Macleod-Pincher Creek to Drumheller; *Angela McIntosh* from Breynat to Tangent.

Ontario

The following is recent news concerning the Ontario Public Health Nursing Service:

Appointments—*Irene Lawson* (Toronto Western Hosp.; University of Toronto certificate course; U. of T. advanced course in administration and supervision in public health nursing), formerly assistant district superintendent, Hamilton branch, Victorian Order of Nurses, as public health nursing supervisor, Welland and district health unit; *Nora Kenney* (Guelph Gen. Hosp. and U. of T. general course), formerly senior public health nurse, Dufferin County health unit, as public health nursing supervisor, Guelph board of health.

Dorothy Adams (Winnipeg Gen. Hosp.; U. of T. gen. course; McGill University admin. and supervision in public health nursing course), formerly public health nursing supervisor, Lennox and Addington health unit, as senior nurse, Oxford County health unit—to staff of this unit: *Dorothy (Boyd) Johnston* (U. of T. diploma course), formerly senior public health nurse, Woodstock board of health, and *Joy (Daniels) Waterhouse* (Toronto Gen. Hosp. and University of Western Ontario cert. course); *Mary Ranney* (B.Sc.N., U.W.O.) as senior public health nurse, Perth County school health service.

Vida Abbott (Brantford Gen. Hosp. and U. of T. gen. course) to Wellington County health unit; *Ruth Bailey* (Children's Hosp., Halifax, and U. of T. gen. course) to Chatham board of health; *Mrs. Ewart Bonter* (Toronto Hosp., Weston, and U.W.O. cert. course) and *Eleanor Reynolds* (Wellesley Hosp., Toronto, and U. of T. gen. course) to Simcoe County health unit; *Mary Easton* (Women's College Hosp., Toronto, and U. of T. gen. course) to Sault Ste. Marie board of education; *Rae Isaac* (Brantford Gen. Hosp. and U. of T. gen. course) to Galt board of health; *Dora Purdon* (Ross Memorial Hosp., Lindsay, and U. of T. gen. course), formerly with Simcoe County health unit, to Northumberland and

Durham health unit; *Margaret Turner* (Hamilton Gen. Hosp.; U.W.O. cert. course; U. of T. advanced course in admin. and supervision) to Halton County health unit.

Resignations—The following public health nurses have resigned from their positions in order to pursue the advanced course in administration and supervision at the University of Toronto: *Margaret Atkinson* from Kenora-Keewatin area health unit; *Jean Falconer* from Galt board of health; *Hazel Fletcher* on leave of absence from Toronto Department of Public Health; *Olga Friesen* on leave of absence from Kitchener board of health; *Alice Klugman* on leave of absence from the Guelph board of health; *Hazel Wilson* from Ottawa board of health.

Others resigning: *Audrey Anderson* from Halton County health unit; *Mildred* (*Laughlen*) *Fox* as senior public health nurse at North Bay; *Thora Gerow* from United Counties health unit; *Ellen Holland* from Elgin-St. Thomas health unit; *Isabel* (*Husher*) *Lutton* from Peel County health unit; *Jean Phillips* from Dufferin County health unit; *Barbara Wills* from York County health unit.

Metropolitan Health Committee, Vancouver

The following are recent staff changes in the Metropolitan Health Committee, Vancouver:

Appointments—*M. Bell* (St. Paul's Hosp., Vancouver, and B.A.Sc., University of British Columbia); *Mrs. E. Brooks* (Vancouver Gen. Hosp. and B.A.Sc., U.B.C.); *K. Cameron* (V.G.H. and U.B.C. public health certificate); *Mrs. F. Carlberg* (Swedish Hosp. and University of Washington public health cert.); *B. Chalmers* (V.G.H. and B.A.Sc., U.B.C.);

Mrs. A. Colcleugh (St. Paul's Hosp., Vancouver, and U.B.C. public health cert.); *Mrs. M. (Jenkins) Coleman* (V.G.H. and B.A.Sc., U.B.C.); *Mrs. M. Donovan* (Ottawa Civic Hosp. and McGill public health cert.); *E. Hayden* (St. Paul's Hosp., Vancouver, and U.B.C. public health cert.); *Mrs. B. Hutchings* (V.G.H. and B.A.Sc., U.B.C.); *E. Logie* (V.G.H. and U.B.C. public health cert.); *H. MacPherson* (St. Paul's Hosp., Vancouver, and B.A.Sc., U.B.C.); *M. McDiarmid* (V.G.H. and B.A.Sc., U.B.C.); *F. McLaren* (Royal Hosp. for Sick Children, Glasgow, and University of Edinburgh health visitor cert.); *M. Small* (Montreal Gen. Hosp. and McGill public health cert.); *F. E. Waddell* (B.Sc., University of Alta.); *E. Ward* (Victoria Hosp., Winnipeg, and University of Man. public health cert.); *M. Whitecross* (Royal Jubilee Hosp., Victoria, and U.B.C.); *Mrs. E. Williamson* (Royal Columbian Hosp., New Westminster, and U.B.C. public health cert.); *Mrs. A. Wong* (V.G.H. and B.A.Sc., U.B.C.).

Exchange—*M. McLaughlin* is on a year's exchange to the B.C. Dept. of Health and Welfare and will be at Powell River; *Gertrude Rollo* of the provincial staff is the nurse exchanging.

Leaves of Absence—*E. Leighton* to attend McGill; *S. Ogilvie* to attend Berkeley; *E. Williamson* to attend Teachers College, Columbia University.

Resignations—*Vida Abbott, Florence Carter, Mrs. B. (Murray) Cullinanne, Jennie Hocking, Betty Huff, Ruth Kennedy, Jean Maxwell, Lila Shields, Ruth Speirs.*

Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada:

Appointments—Brantford: *Leah Enslen* (University of Toronto) and *Pauline Johnson* (University of Western Ontario). Burnaby, B.C.: *Doreen Pope* (University of British Columbia). Campbellton, N.B.: *Jean Haynes* (U.W.O.) as nurse in charge. Chatham, N.B.: *Joan Chisholm* (McGill University) as nurse in charge. Cobalt, Ont.: *Grace Latham* (U. of T.) as nurse in charge. Hamilton: *Ilean Gibson* (U. of T.). Kingston: *Marion (Vine) McNevin* (Queen's University). London: *Lenore Snell* (Victoria Hosp., London). Montreal: *Patricia Corbett, Norma McKee*

(McGill U.), *Victoria Young* (Mary Hitchcock Memorial Hosp., Hanover, N.H.). Saskatoon: *Genevieve MacLean* (University of Manitoba), Toronto: *Glenna Kendall* and *Helen M. Kent* (U. of T.). Vancouver: *Luba Gold* (St. Boniface Hosp., Man.). Victoria: *Eveleen Dunn* (U.B.C.). Weston, Ont.: *Bernice Gibson* (U. of T.).

Transfers—*Anne Baker* from Burnaby to Elphinstone as nurse in charge; *Margaret Graham* from Ottawa to Vancouver; *Marion Hellyer* from Saskatoon to Orillia, Ont., as nurse in charge; *Frances Hicks* from Montreal to Vancouver; *Edna Knutson* from Orillia as nurse in charge to Oshawa as nurse in charge; *Therese Lynch* from Cobalt, Ont., as nurse in charge to Ottawa; *Rosalind May* from Lachine to Ste. Anne de Bellevue, Que., as nurse in charge; *Lena Riddell* from North York as nurse in charge to Niagara Falls as nurse in charge; *Constance Swinton* from Woodstock, N.B., as nurse in charge to Trail, B.C., as nurse in charge.

Leaves of Absence—Dartmouth, N.S.: *Dorothy Loane.* Kingston: *Margaret Donevan.* Lachine: *Germaine D'Allaire, Cecile Vincent.* Port Arthur: *Margery Spencer.* Vancouver: *Phoebe Clement, Bernice Gordon, Ada McEwen, Elizabeth Webster.* Waterloo, Ont.: *Agnes Buckingham.*

Resignations—Brantford: *Helen Ryan.* Burnaby: *Beverly Carlyle, Margaret Whitecross.* Campbellton, N.B.: *Mary Caryll* as nurse in charge. Kirkland Lake: *Marjorie Pexton.* Montreal: *Astrid Jorgenson.* Ottawa: *Beulah Mann.* Saskatoon: *Marion Cawsey.* Sudbury: *Donna Farmer.* Toronto: *Helen Wheler.* Vancouver: *Mrs. A. Colcleugh, Grace Lackey, Eileen Rankin.* Victoria: *Margaret Bawden, Mildred Williams.* Winnipeg: *Anita Claxton.* York Township, Ont.: *Marianne Coleman.*

Nursing Sisters' Association

The *Montreal Unit* held their first general meeting of the autumn in September at Queen Mary Veterans' Hospital when the election of officers to the National Executive (1950-52) took place, as follows:

President, Janet C. MacKay, matron, Lachine General Hospital; first vice-president, Adrienne St. Onge, private duty nurse, Montreal; second vice-president, Nancy Kennedy-Reid, R.R.C., matron, Ste. Anne's D.V.A.

Hospital; third vice-president, Mrs. C. A. Young, Ottawa; honorary councillor, Mrs. Stuart Ramsey, Montreal (first honorary president of N.S.A.C.). Councillors: M. A. Beaumont and Doris V. Watson, head nurses Ste. Anne's D.V.A. Hospital; May S. MacDonald, head nurse, Queen Mary Veterans' Hospital. The secretary-treasurer is Miss Eleanor Johnson, Apt. 8, 80 Hudson Ave., Town of Mt. Royal, Montreal 16; assistant, Miss Rita Ackhurst, 3591 University St., Montreal 2.

The officers and members of the Montreal Unit wish the members of the National Executive every success in all their endeavors.

News Notes

ALBERTA

EDMONTON

An attendance of 39 heralded the opening season of the Instructors Group meeting at University Hospital in September. Elizabeth Bietsch, chairman, gave a complete report on the work done thus far in organizing a film pool for Alberta schools of nursing. J. Mackie was elected chairman of the Film Committee to carry on and complete its organization. H. Penhale introduced Orma Smith, adviser to schools of nursing in Alberta. Lunch was served by the teaching staff of the hospital.

LETHBRIDGE

St. Michael's Hospital was the scene of a meeting of District 8 when about 25 members heard highlights of the C.N.A. biennial convention held in Vancouver. These comments were ably presented by Sr. Mary Peter, A. Short, A. Fallis, and C. Tennant. A student nurse at Galt Hospital—A. Kooy—told about the part played by the students at the convention. Miss Gunn was in the chair, with Miss Killem reading the secretary and treasurer's report. A welcome was extended to Beryl Tiffin, public health nurse from Macleod district.

BRITISH COLUMBIA

CHILLIWACK

Last season there were many busy, friendly times for the chapter and this new season promises to be even more interesting with the executive all real workers. Every member is sure to have a job to do. Perhaps a brief résumé of some of last year's activities will be a good spark to get the 1950-51 season in full swing:

Among the speakers and their topics were: Lucy Hodgkins, former matron, Chilliwack Hospital, on a brief stop-over to renew friendships after three years in England. She thanked the chapter for the food parcels sent overseas. Mr. E. Halsall and his informative talk on "Fine China"; Mrs. L. DeSatge, director of the Home Nursing and First Aid Division of the B.C. Red Cross, telling about this phase of the Red Cross work; Inspector Hewitt from the Women's Division, Vancouver Police; Dr. Anna Farewell's address on "Subdural Hematoma in the Young Child." An old-fashioned garden party and tea was held on the hospital grounds in June.

The series of lectures for chapter members by Fern Trout, itinerant instructor of the R.N.A.B.C., has started. October 21 was the date of the rummage sale.

New Westminster

Two globe-trotting nurses from this city have settled down in Europe to continue their studies. Bernice Graham and Delores Randall, who left here last November on an Australia-bound freighter, have both had their wanderlust satisfied for awhile. They have visited Mexico, Australia, Bombay, Hong Kong, Communist China, Holland, and England. Miss Graham has joined the staff of the Lambeth Hospital where she will take a year's advanced training in obstetrics and Miss Randall is nursing in Holland. Both are former members of the Royal Columbian Hospital staff.

While in Communist China, the girls say they were followed by three machine gun-equipped soldiers everywhere they went. In Hong Kong they picked up a tubercular patient whom they nursed back to health during the voyage to Holland. Both signed on a Norwegian freighter as ship's stewards and enjoyed every minute of their trip. The only unfortunate incident of their trip was the voyage across the Channel when a thief stole Miss Graham's collection of curios she has purchased in the Orient.

Vancouver

Two nursing leaders have been awarded bursaries from the Federal Health Grants for study at Columbia University, New York. Eva M. Williamson, from the Metropolitan Health Committee of Greater Vancouver, will spend a year studying administration of public health nursing services, and Ruth M. Morrison, an assistant professor in the Department of Nursing at the University of British Columbia, will enrol for a year's course in the teaching and supervision of public health nursing. Both courses lead to an M.A. degree.

St. Paul's Hospital

Doreen Corry has returned from Montreal where she completed a post-graduate course. Muriel and Mary Freeze, Gwen White, and Ruby Johnson are nursing in Bermuda.

MANITOBA

BRANDON

Jean Higgens has been awarded the scholarship for post-graduate study sponsored by the Association of Graduate Nurses and various groups in the city, including the medical staffs of the General and Mental hospitals. A 1949 graduate of the General Hospital, she has been on the nursing staff there, acting in an assistant supervisory capacity. She has enrolled at the University of Western Ontario for the course in teaching and supervision in schools of nursing.

NEWFOUNDLAND

ST. JOHN'S

General Hospital

Mary B. Galway has been appointed assistant director of nurses at Nassau Hospital, Mineola, New York. She has been a member of the staff of that hospital since 1945, first serving on the general staff then as pediatric supervisor.

NOVA SCOTIA

HALIFAX

Victoria General Hospital

A reunion of the graduates of the school of nursing was held from September 3-5. Two hundred graduates from many parts of the U.S.A. and Canada attended the first reunion held since the school was founded 60 years ago. Following registration on Sunday afternoon, teas were arranged by the classes. In the evening a service was held in St. Paul's Church. There, a framed portrait of the late Gladys Strum, superintendent of nurses for 23 years, was dedicated by the rector, Canon Isherwood. A gift of her sister, Mrs. Mabel Zwicker, it will have a permanent place in the nurses' home. It was accepted by Maisie Miller, present superintendent of nurses, from Laura Page.

On Monday morning the members enjoyed a coffee party at the nurses' residence. In the afternoon a tour of the new hospital was conducted by the staff nurses. Great interest was shown in the central supply and outpatient department which are new features of the hospital.

In the evening a banquet was held at the Lord Nelson Hotel. Especially honored were three members of the class of 1895—Catherine Graham and Harriet Hamilton, Halifax; Mrs. M. W. MacAulay, Edmonton. Miss Graham, the only one to continue actively in the nursing profession since her graduation, helped to form the Graduate Nurses' Association and held office almost continuously in that association and later in the Registered Nurses' Association. Only recently she retired from the City Health Department. The chief speaker at the banquet was Mrs. Abbie Lane, well-known commentator, whose father was the first medical superintendent of the hospital.

Included in the festivities was a cruise

around the harbor, a bus trip to scenic Peggy's Cove, and a tea in the nurses' residence. The three-day program concluded with attendance at the graduation exercises of the 1950 class. The graduates were presented with their diplomas by Miss Graham and the alumnae prize was presented by Mrs. Harry (Hollaway) Hall, the alumnae's first president. Following the exercises, the alumnae were guests of the hospital at a buffet supper arranged by the head dietitian, Marion Brown, and her assistants in the cafeteria of the new hospital.

The program was organized by a local committee under the direction of Dorothy Gill, general convener.

Graduates of V.G.H. entertained for Frances MacDonald, assistant superintendent of nurses, prior to her departure for Montreal to take post-graduate work in nursing school administration at McGill University. She is on leave of absence for one year. Sylvia Nott has resigned to take the teaching and supervision course at McGill. Jean Church is now clinical instructor.

ONTARIO

DISTRICT 4

GRIMSBY

The fall meeting of the district was held in September when the Board of Directors and staff of the West Lincoln Memorial Hospital contributed mainly to the success of the evening. The tour through the hospital revealed a complete and compact unit—a source of admiration to all. A film—"The Growth of a Hospital"—gave the inside story of how the present building was accomplished. Helene Snedden presided at the business meeting when plans for raising the "Token Grant" and proposals for civilian defence were discussed.

"Staff Orientation and Education" was the topic presented by Grace Patterson, associate director of nursing service, Toronto Western Hospital, and many helpful suggestions were offered to administrators in like positions.

During the social hour, nurses from all parts of the Niagara district enjoyed meeting old friends. To Miss D. MacRobbie and her staff, along with the Niagara Chapter, go the sincere thanks of the district for their hospitality.

QUEBEC

MONTREAL

Jewish General Hospital

The Associate Nurses of the hospital held their opening dinner in October when Evelyn Kessler, director of the school of nursing, Lillian Gass, supervisor of the nurses' home, and Gertrude Gorelick, instructor of nursing arts, were introduced. Plans are completed for the annual supper dance to be held in the ballroom of the Mount Royal Hotel on November 25. Proceeds are in aid of the hospital Cancer Clinic Project. December 6

is Auction Night at the hospital. All members are urged to bring their contributions as soon as possible to Miss McDonald and Miss Chisholm on the third floor. The bowling league meets Wednesday night at St. Mary's Bowling Academy, Cote Ste. Catherine Rd. corner of Cote des Neiges Rd.

SASKATCHEWAN

SASKATOON

St. Paul's Hospital

The new term opened on September 4 with mass, preceded by an inspiring ceremony when the February, 1950, class received their caps at the hands of Rev. C. Kramer, hospital chaplain. On September 7 the new "Freshmen A" passed on their title of "Freshmen B" to the 36 latest arrivals at an entertainment to welcome new faculty members and students.

The clinical year opened on September 12 with a special mass for the graduate staff, followed by a breakfast and introduction of new staff members. All Sisters, staff, and students were x-rayed by the visiting personnel of the mass anti-tuberculosis survey. At that time Dr. D. E. Moore addressed a meeting of graduates in his capacity as chief of staff and pathologist.

A welcome is extended to Rev. Sr. C. Jeanotte who is now assistant to the director of nurses, Rev. Sr. A. Ste. Croix. F. McDonald, science instructor, has returned after an absence of two years. M. Mackenzie continues as nursing arts instructor. Mrs. I. Redston has been joined by S. Leeper and O. Lypka as clinical instructors and L. B. Wilson is now health nurse. N. Quinn and R. Purdy have left to be married.

YORKTON

Mrs. Sam Dodds was elected president for the 1950-51 term at the annual meeting of the General Hospital Alumnae Association. Other officers elected include: Honorary president, Mrs. L. V. Barnes; vice-president, Mrs. J. Parker; secretary, Mrs. M. Campbell; treasurer, Mrs. W. Westbury; social conveners, Mmes H. Ellis, S. Dodds; councillors, sick and bereavement, Mrs. G. Parson, K. Francis; *Canadian Nurse* representative, Mrs. T. E. Darroch.

Miss I. B. Katzberg, administrator of nurses, McAllen Municipal Hospital, Texas, was a welcome guest at the September meeting. She is an associate member and former superintendent and instructor of nurses at the General Hospital.

Mrs. W. (Hornseth) Sharpe was presented with an electric tea kettle when a number of members gathered at the home of Mrs. H. (Widdicombe) Ellis. Mrs. Sharpe and family will reside in Regina where her husband has been appointed Assistant Inspector of Technical Schools.

Rosemary Bertram and Maureen Gibson have resigned their position at Y.G.H. and are now at Flin Flon, Man.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Supt. (qualified) for 60-bed General Hospital. New 125-bed hospital under construction. Apply, giving full particulars & salary expected, Prince County Hospital, G. R. MacQuarrie, Sec., Box 441, Summerside, P.E.I.

Nursing Arts Instructor, Asst. Medical Supervisor & General Duty Nurses for 200-bed General Hospital. Salary: $195 & $175 plus Cost of Living Bonus respectively. 8-hr. day. 88-hr. fortnight. 4 wks. vacation annually plus statutory holidays. Sick time. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

Asst. Instructor in Medical-Surgical Nursing. Temporary position. Duties to commence immediately & to continue till Aug. 1951. Apply, stating qualifications & salary expected, Director, Dept. of Nursing Education, McMaster University, Hamilton, Ont.

Public Health Nurse desiring experience in generalized health program in Southern Michigan, between Chicago & Detroit. Salary range depending on qualifications & experience: $3,000-3,300. Depreciation & mileage allowance on own car. 4 wks. vacation yearly. Liberal sick leave. Field training area for Public Health Nurses. Write Medical Director, District Health Dept., Hillsdale, Michigan.

General Duty Nurses for 60-bed General Hospital. Gross salary: $150 per mo. (less $25 if full maintenance provided). Two $5.00 increases every 6 mos. 3 wks. vacation & allowance for sick time. Apply Supt., Public Hospital, Smiths Falls, Ont.

General Duty Nurses for 220-bed General Hospital. 8-hr. day, 6-day wk. For further information write Miss M. E. Jackson, Supt. of Nurses, General Hospital, Brandon, Man.

Graduate Nurses (2) for General Duty. Live in. Starting salary: $175; regular increments. Less $35 comfortable accommodation. Best climate in Canada. Apply Sec., Chemainus Hospital, Chemainus, Vancouver Is., B.C.

THE PROVINCE OF MANITOBA requires a

SENIOR INSTRUCTOR OF NURSING

for the **Hospital for Mental Diseases, Selkirk, Manitoba.**

Must be Registered Nurse, preferably with Mental Nursing certificate, capable of supervising educational program for undergraduate and graduate nurses, under direction of Superintendent of Nurses.

Deductions will be made for full maintenance and laundry. Regular annual increases, liberal sick leave with pay, 4 weeks' vacation with pay annually, pension plan, etc. Apply, giving particulars of age, education, qualifications, and salary expected, to:

MANITOBA CIVIL SERVICE COMMISSION
247 Legislative Building, Winnipeg, Manitoba

Graduate Nurse at once for new modern 20-bed hospital. Salary: $150 per mo. & full maintenance. 8-hr. day, 6-day wk. 2 wks. with pay end of yr. Community near U.S. border. English-speaking population. Apply P. J. Rasmussen, Sec., Community Hospital, Climax, Sask.

Matron & Registered Nurses (2) for modern 20-bed hospital. Salary: $210 & $180 per mo. gross. Usual holiday time & sick leave. Apply E. W. Groshong, Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Night Supervisor & General Duty Nurses. Apply, stating experience & qualifications, Supt., Queens General Hospital, Liverpool, N.S.

British Columbia Civil Service requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Maintenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

Registered Nurses for General Duty at Grand Forks (B.C.) Community Hospital—30 beds. 44-hr. wk. Cumulative sick leave, statutory holidays & 2 wks. after 6 mos. service & 1 mo. after 1 yr. service. Gross salary: $175, less $30 which includes meals, laundry, living accommodation in hospital residence. Railway fare up to $50 with 1 yr. service. Splendid climate. Good shopping facilities locally with easy access to Nelson & Penticton, B.C., & Spokane, U.S.A. Apply John A. Hutton, Sec., Grand Forks, B.C.

General Duty Nurses. Gross salary: $163.40 per mo. 8-hr. broken day, 48-hr. wk. All salaries have scheduled rate of increase. Cumulative sick leave. Pension Plan in force. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

WANTED

GENERAL DUTY NURSES

For Provincial Institutions in Province of New Brunswick

Salary: Minimum $1,620; maximum $1,740. Annual increase of $120 plus Monthly Bonus of 16%.

Comfortable living quarters and full maintenance supplied for $30 per month. Nurses' quarters open for inspection at any time.

Applications should be made to **Chairman, New Brunswick Civil Service Commission, P.O. Box 906, Fredericton, N.B.**

Asst. Operating Room Supervisor. Post-graduate course essential. Gross salary: $185. **Graduate Nurses (2) for General Duty in O.R.** 48-hr. wk. 3 wks. annual vacation. Sick time. Gross salary: $169. Apply Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ont.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. Large, well-equipped modern hospital (5,137 births in 1949) with opportunities for wide experience in Obstetrical Nursing. Vacancies on Delivery Floor, Nurseries, Postpartum Floors. 44-hr. wk. Statutory holidays. Bi-weekly salaries: $76-88. For other perquisites & further information write Supt.

Night Supervisor for Mt. Hamilton Maternity Hospital, Hamilton, Ont., as Second Assistant. 40-hr. wk. Statutory holidays. 1 mo. vacation after 1 yr. service. Cumulative sick benefits. Salary: Bi-weekly $88-100. For further information write Supt.

Registered Nurses with Public Health Training & experience, preferably generalized; not over 35 yrs. of age. Initial salary: $2,400 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 112 College St., Toronto 2, Ont.

Vancouver General Hospital requires: (1) **Pediatric Clinical Instructor**—Salary: $207-232; (2) **Clinical Instructor** (to include Gynecological Nursing)—Salary: $207-232; (3) **General Staff Nurses**—Salary: $177-207. Perquisites: 44-hr. wk; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; pension plan (if under age 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

Registered Nurses for new 60-bed General Hospital in prosperous farming community near U.S. border. Salary: $125 per mo. with full maintenance. 6-day wk. Blue Cross paid. $60 per yr. increase up to 3 yrs. 10 days sick leave per yr. 3 wks. holiday per yr. plus 6 days statutory holidays. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Staff in 21-bed hospital. Salary: $140 per mo. Room, board and uniform laundry provided. Rotating shifts, 48-hr. wk. Blue Cross plan. 3 wks. holiday after one year's service. Apply Superintendent of Nurses, General Hospital, Espanola, Ont.

Registered Nurses for following positions in 185-bed hospital (full maintenance in addition to salary): **Night Supervisor**—$175; **Asst. Night Supervisor**—$150; **Floor Supervisor** (women's floor)—$155; **General Duty Nurses**—$130; **Instructor**—$200; **Clinical Supervisor**—$160. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Operating Room Nurses (experienced). Apply Director, Nursing Services, Toronto Hospital for Treatment of Tuberculosis, Weston, Ont.

Matron by Dec. 1 for County Hospital, Huntingdon, Que. Salary: $170 per mo. Full maintenance & 1-mo. vacation per annum. Huntingdon is a growing community, plenty of social activity & hospital staff work & live in a most congenial atmosphere. For further particulars apply Dr. F. G. McCrimmon, Hospital Supt.

Operating Room Nurses & Graduate Nurses for General Duty in 340-bed General Hospital in Metropolitan New York area, half-hour from New York City. For further information apply Director, Nursing Services, Presbyterian Hospital, Newark 7, New Jersey.

Graduate Nurses for General Duty & willing to assist in Operating Room. Good salary with full maintenance. Apply Supt., Rosamond Memorial Hospital, Almonte, Ont.

CITY OF TORONTO

DEPARTMENT OF PUBLIC HEALTH

Qualified ***Public Health Nurses*** for a generalized public health nursing service. Salary $2,087 with yearly increases to $2,504 per annum, plus $4.00 weekly Cost of Living Bonus. Five-day week. Sick leave and pension plan benefits.

Apply **Personnel Department, Room 320, City Hall, Toronto.**

The Public Service of Canada requires

HOSPITAL NURSES

up to $2,460 for the Department of Veterans Affairs at various centres.

● Employees may proceed by promotion to as high as Hospital Matron, Grade 4, with a maximum salary of $3,660 per annum. *Details and application forms at* **Civil Service Commission Offices, National Employment Service Offices and Post Offices.**

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Registered Nurses for General Staff Duty on Rotation Service. Apply, Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

General Duty Nurses for 400-bed hospital. New Wing just opened. 8-hr. day, 44-hr. wk 10 statutory holidays. B.C. registration required. Salary: $175 basic. Credit for past experience Annual increments. Vacation: 28 days after 1 yr. Sick leave: 1½ days per mo. cumulative Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses (2) immediately for new 17-bed Municipal Hospital, Elnora, Alta. Pleasant working conditions. Beginning salary: $125 per mo. with full maintenance. Hospital Board will pay railway fare if period of employment is 6 mos. or over. Apply A. J. Schmiedl, Sec.-Treas.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 48-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Clinical Supervisor. Apply Supt. of Nurses, Victoria Public Hospital, Fredericton, N.B.

General Duty Nurses (2) for 20-bed hospital. Salary: $165 per mo. plus full maintenance. The hospital serves a wide ranch area, giving varied experience. Suitable for newly graduated nurses. Apply Miss L. V. Stanford, R.N., Bishop Randall Hospital, Lander, Wyoming.

General Duty Nurses. 44-hr. wk. Vacation with pay. Sick leave. Good salaries. Write Miss Margaret Beard, Personnel Director, Highland Park Hospital, Highland Park, Illinois.

CANADIAN RED CROSS SOCIETY

invites applications for ***Administrative*** and ***Staff*** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

THE GREATEST NEED FOR OUTPOST NURSES IS IN THE PROVINCE OF NEW BRUNSWICK — BOTH AT MATRON AND STAFF LEVEL.

- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:
National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

WANTED

General Duty Graduate Nurses & Operating Room Supervisor for 270-bed Sanatorium to be opened ***Jan. 1951.*** *Salary:* $1,150 & $1,240 per yr. respectively, with Cost of Living Bonus & annual increments, plus uniforms & laundry & full maintenance in beautiful new Nurses' Home. 44-hr. wk. & rotating shifts. 4 wks. annual vacation. 17 statutory holidays & paid sick leave after 2 mos. service. Apply **Supt. of Nurses, West Coast Sanatorium, Corner Brook, Newfoundland.**

THE CENTRAL REGISTRY OF GRADUATE NURSES, TORONTO

Furnish Nurses at any hour DAY or NIGHT

TELEPHONE **Kingsdale 2136**

Physicians' and Surgeons' Bldg., 86 Bloor Street, West, TORONTO 5.
WINNIFRED GRIFFIN, Reg. N.

Registered Nurse immediately for 3-year-old hospital. 21 adult beds plus 7 bassinettes & children's beds. Salary: $150 per mo. plus full maintenance. 8-hr. day. 6-day wk. 1 mo. holiday with salary per annum. Private rooms in nurses' residence. Good train connection daily except Sun. to Regina & Saskatoon. Wire or phone collect Matron, Union Hospital, Leroy, Sask.

Operating Room Nurses for General Surgery *or* Eye, Ear, Nose & Throat work, due to expanding services. For information apply Supt. of Nurses, Hospital for Sick Children, Toronto 2, Ont.

Public Health Nurses for Dept. of Health, City of Ottawa. Generalized Public Health Nursing program. Minimum salary: $2,280 per annum. Apply P. Stiver, Director, Public Health Nursing, Dept. of Health, Transportation Bldg., 48 Rideau St., Ottawa, Ont.

Registered Nurses for General Duty. 8-hr. day, 48-hr. wk. Total 6 mos. day duty—6 mos. evening & night duty in yr. Gross salary: $145 per mo. days; $150 evenings & nights. Residence accommodation available. Apply Director of Nursing, General Hospital, Belleville, Ont.

Operating Room Nurse with post-graduate course for 60-bed General Hospital. Apply Supt., Public Hospital, Smiths Falls, Ont.

Dietitian for 270-bed Sanatorium to be opened Jan. 1951. Salary: $1,500 with prevailing Cost of Living Bonus & annual increments, plus uniforms, laundry & full maintenance in beautiful new nurses' home. 44-hr. wk. 4 wks. annual vacation. 17 statutory holidays. Sick leave after 2 mos. service. Apply, stating qualifications, age & experience, Supt. of Nurses, West Coast Sanatorium, Corner Brook, Newfoundland.

Operating Room Nurse with post-graduate training. $190 per mo. less $35 room & board. Annual increases. 100-bed hospital, 60 miles from Vancouver on Trans-Canada Highway in Fraser Valley. 44-hr. wk. 28 days holiday after 1 yr. 10 statutory holidays allowed. Apply Director of Nurses, Chilliwack Hospital, Chilliwack, B.C.

Registered Nurses (2) for General Duty for 35-bed General Hospital, 50 miles from Toronto. Apply, stating qualifications, Supt., Lord Dufferin Hospital, Orangeville, Ont.
